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

JOINT LEGISLATIVE HEARING

In the Matter of the
2018-2019 EXECUTIVE BUDGET
ON HEALTH AND MEDICAID

Hearing Room B
Legislative Office Building
Albany, New York

February 12, 2018
10:04 a.m.

PRESIDING:

Senator Catharine M. Young
Chair, Senate Finance Committee

Assemblywoman Helene E. Weinstein
Chair, Assembly Ways & Means Committee

PRESENT:

Senator Liz Krueger
Senate Finance Committee (RM)

Assemblyman Robert Oaks
Assembly Ways & Means Committee (RM)

Senator Kemp Hannon
Chair, Senate Committee on Health

Assemblyman Richard N. Gottfried
Chair, Assembly Health Committee

Senator David J. Valesky
Vice Chair, Senate Committee on Health

2018-2019 Executive Budget
Health and Medicaid
2-12-18

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

Senator James Tedisco

Assemblyman Phil Steck

Assemblyman Andrew Garbarino

Senator Elizabeth O'C. Little

Assemblyman John McDonald

Senator Martin J. Golden

Assemblyman Edward P. Ra

Senator Patricia A. Ritchie

Assemblywoman Michaelle Solages

Assemblyman Kevin M. Byrne

Assemblywoman Rodneyse Bichotte

Assemblywoman Patricia Fahy

Senator James Sanders

Assemblyman Walter T. Mosley

2018-2019 Executive Budget
Health and Medicaid
2-12-18

PRESENT: (Continued)

Senator Roxanne Persaud

Assemblyman James Skoufis

Senator Timothy Kennedy

Assemblyman Felix Ortiz

Senator Susan Serino

Assemblyman Thomas J. Abinanti

Senator Todd Kaminsky

Assemblywoman Jo Anne Simon

Senator Brad Hoylman

Assemblywoman Nily Rozic

Assemblywoman Aileen M. Gunther

Senator Marisol Alcantara

Assemblywoman Rebecca A. Seawright

2018-2019 Executive Budget
Health and Medicaid
2-12-18

LIST OF SPEAKERS

LIST OF SPEAKERS, Continued

LIST OF SPEAKERS, Continued

LIST OF SPEAKERS, Continued

LIST OF SPEAKERS, Continued

LIST OF SPEAKERS, Continued

CHAIRWOMAN YOUNG: Good morning. Good morning. Would everyone please take your seats.

Good morning. I'm Senator Catharine Young, and I'm chair of the Senate Standing Committee on Finance. I'm very pleased to be joined this morning by my colleague Assemblywoman Helene Weinstein, who is chair of Ways and Means.

And I'll begin by introducing some of the other legislators that are here today. We've got Senator Diane Savino, who is vice chair of the Finance Committee; Senator Liz Krueger, who is ranking member; Senator Kemp Hannon, who is chair of the Senate Standing Committee on Health. Vice chair of Health is Senator David Valesky. We've got Senator James Seward, chair of the Insurance Committee; Senator Rivera; Senator Sanders; Senator Tedisco; and Senator Little.

Chairwoman?

CHAIRWOMAN WEINSTEIN: I'm Helene Weinstein, chair of Ways and Means. And joining us is Assemblyman Dick Gottfried,

chair of our Health Committee; Assemblyman John McDonald; Assemblywoman Michaelle Solages; Assemblywoman Rodneyse Bichotte; Assemblyman Phil Steck; and Assemblyman Walter Mosley.

And Bob Oaks, our ranker on Ways and Means, will introduce the Republican members here.

ASSEMBLYMAN OAKS: Yes. We're joined by Andrew Raia, ranker on the Health Committee; Andrew Garbarino; and Kevin Byrne.

CHAIRWOMAN YOUNG: 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.

First I'd like to welcome Dr. Howard

Zucker, commissioner of Health. Following the presentation by Dr. Zucker will be Dennis Rosen, Medicaid inspector general, followed by Maria Vullo, superintendent of the Department of Financial Services.

Testimony will be followed by a question-and-answer period by members of the Legislature.

So at this time we would like to begin with the testimony of Commissioner Zucker. Welcome.

COMMISSIONER ZUCKER: Good morning. Good morning, Chairpersons Young and Weinstein, Hannon and Gottfried, and members of the New York State Senate and Assembly. I'm here to present Governor Cuomo's 2018-2019 Executive Budget as it relates to healthcare.

I am joined by Jason Helgerson, the State Medicaid Director.

You have a more comprehensive version of my testimony before you, but I will be delivering an abbreviated version this morning.

For four years I've had the distinct honor of overseeing the Department of Health. The over 5,000 employees of the department are at the front line of every response to protect the health, safety and well-being of New York's residents. In just the past 12 months, we have addressed Zika, Legionella, harmful algae blooms, unregulated contaminants in drinking water, outbreaks of hepatitis A, measles, mumps, and the list goes on.

A case in point of how the department responds to threats is the one we are facing right now: the flu. One hundred years ago, the influenza pandemic of 1918 killed tens of millions of people worldwide. It was an unusual strain of virus and attacked young, otherwise healthy adults, and at that time we barely understood what caused the flu, much less how to prevent and treat it.

Today we are much more knowledgeable about the flu. Still, we are rightfully and understandably concerned about this year's flu season. The number of confirmed cases

and hospitalizations are the highest since we started tracking in 2004. The flu response we are engaging in highlights not just the advances in science and public health that we have achieved in the century since the influenza pandemic, but also the expertise, the planning, the leadership and coordination that the department utilizes each time there is a threat to the health and safety of New Yorkers.

More New Yorkers than ever have access to high-quality, affordable health insurance: 4.3 million people have enrolled in our New York State of Health. The Medicaid program serves over 6 million members, and spending per person has declined by 5 percent since 2011, without impacting eligibility or quality of care.

New York now ranks among the top 10 states in the nation for health. New York has been designated the first age-friendly state in the nation by the AARP and the World Health Organization. And in 2017, Governor Cuomo directed all agencies to include health

and healthy aging in their policymaking.

Yet despite all of this success, we face an unprecedented assault from Washington. This includes attempts to repeal the Affordable Care Act, putting healthcare for millions of New Yorkers, and billions of dollars in federal funds, at risk. Cost Sharing Reduction payments have been withheld, and after a 114-day funding lapse, federal lawmakers finally reauthorized the Children's Health Insurance Program, CHIP, as part of the spending bill to reopen the government -- for the first time. In the wee hours of the morning on Friday, to reopen the government the second time, funding for Community Health Centers, which has been on life support, was approved. So I ask myself, when did the health and well-being of vulnerable New Yorkers become negotiable?

The Governor embraces the diversity of New York and promotes health equity. It is visible in his directives to expand access to affordable quality healthcare and protect entitlements, marriage

equality, transgender rights, and Medicaid coverage for DACA recipients. And to that end, in this year's Executive Budget we see a mixture of innovative spending, savings, and revenue-generating proposals.

The Executive Budget includes $600 million in additional funding, $750 million total, for the construction of a new life sciences laboratory in the Capital District. This positions New York to attract private investment and jobs to the Capital District with a modern, consolidated Wadsworth Center as the focal point, forming the basis for a revitalized and enhanced life science cluster.

The Wadsworth Center is regarded as the finest state public health laboratory in the United States. The core functions of Wadsworth include screening newborns for 47 treatable conditions, performing testing to detect infectious disease agents and environmental toxins, and responding to emerging threats such as pandemic influenza.

I would note that Wadsworth has been

around since before the influenza pandemic of 1918. And Wadsworth is a reference laboratory, not a conventional clinical or environmental laboratory. We perform the complex analyses that hospitals and commercial laboratories cannot or will not do.

Research at Wadsworth has resulted in over 100 patents in the past 25 years. Wadsworth is working with the Empire State Development Corporation to expand our partnership with private entities to develop products and services that benefit the health of New Yorkers. Through such collaborations, Wadsworth would be well-positioned to be the lab that develops the much-needed universal flu vaccine.

The dedicated staff at Wadsworth are frequently asked to meet new challenges. In the past year, they have worked around the clock to test public water supplies affected by harmful algae blooms, to develop new methods for testing for PFCs. And in recent years, the Wadsworth staff partnered on the

development of new blood tests to distinguish the Zika virus from other closely related viruses, screened samples for synthetic cannabinoids, performed safety testing on all New York medical marijuana products, and stood ready to help Puerto Rico on newborn screening after Hurricane Maria.

Later this week we will be honoring Dr. Joachim Frank. Dr. Frank received the 2017 Nobel Prize in Chemistry for the work he performed at Wadsworth.

The department's commitment to all New Yorkers is unwavering. The staff have been perfecting, improving and promoting the health, well-being, and productivity of New Yorkers since 1901, and one example is our current flu response. These efforts involve staff from nearly all of the department's divisions, in collaboration with other agencies and local health departments, with healthcare facilities and providers. Staff actions include extensive flu surveillance, liaising with the CDC, providing technical assistance to local

health departments, ensuring adequate supplies of vaccines and antiviral medications, and of course prevention education.

The Executive Budget includes an increase in the Department of Health's workforce. The increase is related to the needs associated with the state takeover of Medicaid administration and operational support for surveillance and certification activities.

So when one looks at the bigger picture, we see that among the most vulnerable New Yorkers are children in their first years of life. The First 1,000 Days of Life initiative will implement evidence-based recommendations to improve outcomes and opportunities for young children and their families. And as a pediatrician who's spent time in regions of the world that have experienced conflict and natural disasters, I'm keenly aware of the impact that adverse experiences can have on a young child's life.

Another science-based intervention to

protect children and improve their opportunities and outcomes is our primary prevention approach to lead poisoning. Children under six years of age are more likely to get lead poisoning than any other age group. And lead exposure during pregnancy can impact the developing fetus. The physical, the behavioral, the cognitive impacts to a child from lead poisoning are irreversible. I've seen it.

The Governor's Executive Budget includes a proposal to require the identification of lead hazards as part of residential housing inspections. This is based on a 2006 Rochester program that effectively reduced children's exposure to lead, resulting in fewer children with elevated blood lead levels.

There are several proposals in the Governor's Executive Budget that seek to improve access to care closer to where people live. The budget supports investments in Medicaid reimbursement for ambulance services and also supports rural emergency medical

services. In the coming weeks, we will be releasing public service announcements to encourage more people to become EMTs, emergency medical technicians.

In addition, the regulatory modernization initiative, or RMI, has proposed expanded opportunities for EMS personnel. RMI was a stakeholder-engaged effort to better align the department's regulations with health system transformation. This proposal creates collaborations to allow EMS personnel to provide non-emergency services within their existing scope of practice.

And also from the RMI is a proposal to expand Medicaid telemedicine services to anywhere the patient is located, including their home. It will also expand the types of telehealth services covered. This allows for greater access to remote patient monitoring and alternative healthcare delivery models.

A $425 million capital investment for healthcare providers is included in this year's Executive Budget, and $60 million of

the $425 million will be directed towards community-based providers. This dovetails with another proposal to expand access to assisted living program slots in high-needs areas. A portion of these funds will also be targeted for its information technology and telehealth projects.

And we are proposing a savings through consolidations, efficiencies and modernization of program administration and the reduction of duplication.

As we have said for months now, this budget year is an exceptionally challenging one. In October 1918, "epidemic influenza" became a reportable disease in New York. And as the commissioner at that time, Dr. Hermann Biggs, said: "Efficient boards of health are as necessary to the security and well-being of the community as fire and police departments."

As we consider the evolution of the science of medicine and of healthcare delivery over the last 100 years, I am immensely proud of the work of New York

State's Department of Health. These exceptionally talented people are looking out for the health of all of us.

Finally, as the health commissioner, as a doctor, I would be remiss if I didn't add this one final point, that I urge you all to get your flu shot. I hope you all did get your flu shot. And if not, please do so. This is very important for the safety of you and the safety of everyone in the community.

And so I thank you very much, and I'll be happy to answer any questions.

CHAIRWOMAN YOUNG: Thank you, Dr. Zucker.

Our first speaker will be Senator Kemp Hannon.

SENATOR HANNON: Good morning, Doctor. I'm glad you don't have to wear a mask here to testify because of the flu, but everybody in the hospitals I'm sure are doing it now.

There's a number of great things that are happening. You talk about New York being in the top 10. And I saw the statistic, even though HANYS is promoting it all over the

place, but I thought the biggest part of that statistic was where New York had been just six years ago and how much it had moved from lower double digits up to 10. So there's -- progress can be made.

But I find there's a need really to focus on some bigger picture. One, since you mentioned Wadsworth and since you're honoring a former professor there at Wadsworth who got the Nobel Prize later this week, I think it's real -- and I've had a chance, and many people in the Legislature have had a chance to go and tour Wadsworth. And what we had taken for granted is useful to be reminded of.

But the biggest mystery is, after two years of discussing to upgrade and replace Wadsworth, is that this administration has yet to tell us where they propose to put it. And I think you can't move forward with the dynamic unless you're going to go through the whole -- and it's not an easy process. We have location problems about everything, from tunnels to bridges to soccer stadiums and all

of that, throughout the state.

So I would think that something as needed as Wadsworth, and a replacement and an upgrade, they should come forward and say where it ought to go and what ought to be done about it.

COMMISSIONER ZUCKER: So thank you for those comments and the question. We are looking at -- we are looking at where in the Capital District the lab will be placed. The important thing here is to make sure that when we build a new lab, that there's an opportunity for cross- fertilization of ideas among scientists, researchers, clinicians, and experts. And so this is something in progress, and I hope to have an answer soon for you about that.

SENATOR HANNON: Well, you've proposed it in the budget, and the budget's going to be due soon and it's going to be adopted soon. And after that, I don't see any dynamic. So if you want to move it forward this year, I would think that locating it in the Capital District, which is not a small

amount of territory, is a good thing to identify.

You brought into play the correct comment about the transient nature of policy in Washington. But I think that since the budget was proposed, there's been several major changes that have happened from Washington. The DSH payments, the Disproportionate Share payments, that's been established that it will not terminate soon, another few years, and that's hundreds of millions of dollars to New York hospitals. We have the Child Health Plan that's not only for a few years, I think it's for 10 years now, under two successive actions by Congress. So all of that money is going to be forthcoming. We have the primary care -- we have the Federally Qualified Health Clinics that received their monies. We've actually, even though people had the rhetoric of ending Obamacare, they've not ended it. The amount of money that will come to the state's option for an Essential Health Plan will get more money.

So that hundreds of millions of dollars is now present in the fiscal future that were not there when the budget was presented, and yet the rhetoric hasn't changed, the proposals haven't changed, I haven't seen any solid things as to what's going on, and we still have projections that we have to have a windfall profit tax -- which is not even originally going towards health -- and we have to take money from conversions, which we don't know where they're going, it's not towards health.

So the whole picture, the broad strokes of the health budget, not so much in delivering health, but in financing health, really need to be changed so that an intelligent budget can be adopted.

COMMISSIONER ZUCKER: I think that we are pleased with the outcome of what has transpired. We're not pleased with the process of what has happened in Washington, and there's just a lot of uncertainty there. And I hear what you mentioned about DSH, and we recognize that, and CHIP. But again, we

are not pleased with the process of how this moved forward.

SENATOR HANNON: One of the problems I have with the DSH is that it was originally adopted when Obamacare was adopted, and it was adopted because it said that the hospitals would get more patients who would be able to pay, and therefore they don't need the disproportionate payment.

And in fact, we've had a long lead-up, and I don't know that hospitals have responded at all. Moreover, I see that the state, because of the health exchange, the Obamacare -- the successful implementation of Obamacare in New York, has reduced our uninsured by half. And yet we still, quote, need DSH? The logic, to me, does not add up. Where -- we can't always just be giving more and more money.

You're sitting next to the person who's quarterbacked the DSRIP, the federal waiver, leading to changes in basic delivery of services. But when are we going to start acknowledging things have changed?

COMMISSIONER ZUCKER: Thank you.

SENATOR HANNON: Yeah, you're not going to answer.

(Laughter.)

DIRECTOR HELGERSON: Yeah, I guess I just add, on the uncertainty part, I mean, the president of the United States is going to submit his budget today. There are already signals coming out that reductions in spending in -- sort of outside the Pentagon are going to be quite steep. We'll have to wait and see what those reductions are. Clearly signals are that the Affordable Care Act remains in the sights, not only of the president but certainly of the leadership in the Congress. And so I think that, you know, there's just tremendous uncertainty still out there today.

On DSH, I hear your point relative to the issue about do -- for how long do hospitals need additional support above and beyond the payments they receive directly for services that they provide. But I do think that the transition we're going through in

healthcare, not only because of DSRIP but just even outside of DSRIP, is stressing hospitals in that sector more than it's ever been stressed before. The margins in the hospital sector in New York are as weak as they are in any hospital sector in the country.

And, you know, our hope all along with DSRIP was a smooth transition where we reduce our reliance on hospitals, expand access to other services in the community and not have the major disruptions in care that potentially could occur from, you know, a closure or a series of closures of hospitals.

And so -- but that said, you know, this is a big complex system that makes up a sixth of our economy, healthcare. And transitioning from the old world to the new takes time. And I think our point on DSH, certainly in our discussions previously with the Obama administration and more generally our advocacy is that, you know, the administration of the day had the opportunity to decide how they wanted to allocate those

DSH cuts. And what we said is that you should look at reducing the reduction in DSH for states like New York that did everything in their power to expand access, as opposed to states like Texas who didn't.

SENATOR HANNON: Let me go back to what you're talking about DSRIP. The original grant of several billion dollars to New York was the object to cut admissions to hospitals -- not readmissions, but admissions to hospitals by 25 percent.

DIRECTOR HELGERSON: Correct.

SENATOR HANNON: Obviously people would still be sick, so we moved them to a clinic or to outpatient.

What's been the progress getting there? Because we're now just a little more than halfway through. And if we don't meet the goal, I was told originally that we're going to have to pay the money back.

DIRECTOR HELGERSON: Right. Great question, glad to have the opportunity.

Overall, we feel DSRIP has been a tremendous success so far. The PPSs, the

Performing Provider Systems created under this initiative, have earned 95 percent of the possible funds. And so I know as you know well, this is a performance-based program, so you have to perform in order to get paid. So far they are performing as expected.

Generally speaking, the reductions in avoidable hospital use are on target for the 25 percent reduction over the five years. I think so far it's 13, 15 percent reduction in each of the major measures -- that's admissions, readmissions and emergency room visits. And I want to emphasize too that DSRIP is about potentially preventable of those visits, not just overall.

But overall, we are seeing absolutely positive movement in the data to show that the initiative is working. So overall we're very -- we're very pleased.

Now, we are going into the performance phase where more of the funds are linked directly to outcomes for Medicaid members, and that's a heavier lift. But what I can

say is just last week we were in Staten Island, 650 people from all across the state came together for our annual DSRIP symposium, meeting, basically our conference. We had observers from five countries. Multiple states, multiple academic universities from around the country and outside the United States came to observe. And it's really a tremendous amount of wonderful things going on thanks to that initiative.

SENATOR HANNON: With all of that happening as a positive, I still find the problem with the diversion of monies from healthcare to be problematic. You propose monies that would be going on a tax on opioids, and yet it's not used for further prevention of addiction or rehabilitation. You propose a conversion tax on what's a proposed takeover of Fidelis by Centene, and that money seems to go to the General Fund. And if it doesn't go to the General Fund directly, it goes to HCRA and then to the General Fund.

I find all of these large amounts of

money not to be generating better health but to be generating better fiscal policy for the Budget Office, not for the Health Department. Is there any conversation about changing those things or meeting our points that these are not good directed expenditures?

COMMISSIONER ZUCKER: Well, I do think that it does add up to improved health. I mean, the issue of the opioid tax is the money will go to help looking at how to prevent and to treat those who have been -- prevent those who are potentially exposed to this epidemic or end up a victim of this epidemic, and go to treat those who are actually unfortunately suffering from the challenges of opioid addiction.

And I do think that the monies that we are allocating for different projects are really targeting the improvement of and the well-being of those in New York. I hear what your concerns are, but I do think that we take it very seriously and make sure that the money is directed to programs for the public health.

SENATOR HANNON: One of the bigger problem areas outside of the big-picture hospitals is long-term care in this state. And I find the policy initiatives of this budget kind of gratifying, because things have been done that I didn't like, before, and yet still the change in direction is puzzling.

What do I mean by that? The movement has been to try to get everybody to the very last person in this state who is ill into some type of managed-care program. So a few years ago it was said and it was adopted, everybody going into a nursing home would now be part of managed care. And that was always problematic to me because they were already in a nursing home. I didn't see how management of the care could be better unless somehow the nursing homes were deficient. But then again, if they were deficient, they should be written up.

So this year I see that after six months of being in the nursing home, you're no longer on managed care. And it's a

puzzling change of direction.

It's the same puzzling change of direction because I don't see the proposals in regard to children's behavioral health making any sense. We had originally said they should be part of a managed-care system. That's drawn back into some type of quasi-managed care right now.

We have people who are traumatic brain injured, we keep on passing -- Assemblyman Gottfried and myself keep on passing waivers for a year or two, because that's not a population that is appropriate.

So I -- and I don't find all of these directions where we're supposed to be allowing managed care to go off on its own and work, we're supposed to be allowing others areas to go off on their own and work, and yet the interference by the state keeps on hampering those types of directions. And I don't see it working.

DIRECTOR HELGERSON: Sure. So definitely I can answer that.

So if you go back to the beginning of

Medicaid redesign, one of the core tenets was this concept of care management for all. And so over the past several years we've been moving populations and services into managed care. Back when we started this effort, one of the hopes that we had was that we'd be able to work to establish a strong partnership with the federal government relative to dually eligible individuals, individuals enrolled in both Medicaid and Medicare. Most of the nursing home population, 80 percent of individuals in nursing homes, are dually eligible.

And that's important in the move to managed care for that population, is that if you do effective work in terms of care management in the nursing home, what you're in essence hoping for out of that effective care management is the opportunity to keep people out of the hospital, to avoid hospital services, whether that's trips to the emergency room, inpatient and such.

The challenge that we have is that despite a lot of effort, including a -- we're

one of multiple states that did a demonstration -- we have not been able to find a way to establish a good working relationship with the federal government relative to duals. And that directly impacts the value proposition of having individuals in nursing homes who are in long-term permanent stays in nursing homes, having them enrolled in managed care.

The proposal that is included in this year's budget is if someone has been deemed to be in need of a permanent placement -- and just to be clear, a permanent placement is a discussion that goes on between the individual, their family, the nursing home, the local district, about whether or not this is really someone who's there for maybe a period of rehab, there's alternative options, but they're in a permanent stay. And then they're -- once deemed in a permanent stay, they're in for another six months.

The idea then is we would disenroll them from managed long-term care because in essence we pay the nursing home to do those

basic care management --

SENATOR HANNON: We knew that -- we knew that before. We had brought that point before. And I find the zigzagging of this policy to be just problematic. You have another proposal in regard to limiting the amount of LHCSAs that can be contracted with by a managed long-term care.

The trouble is that the State Public Health Council keeps on approving new licenses for LHCSAs. There's a deluge of them every meeting. And yet now we want to cut back through the budget.

This does not give me a sense of strong direction and policy. And it really comes about because it's a case-by-case basis when it comes to long-term care. We don't see it, we just know from the protests that come to our office that something is not going on correctly.

DIRECTOR HELGERSON: So just on -- just so I can finish the point on the nursing homes, that the rationale for the carve-out now is that there really isn't the

opportunity to capture shared savings, there isn't the opportunity to do value-based payment, because we haven't been able to figure out with the federal government how to effectively coordinate between the two payers.

So in that sense, because we don't see any change coming from the Trump administration on this issue, that at this point it doesn't make sense for us to pay, in essence, the care management fee twice.

As to the LHCSA proposal, it is true as the -- as we see the landscape within the Medicaid program, we see 1400 LHCSAs, most of whom are very small organizations, most of whom are for-profit entities, and we see that it's difficult for our managed-care organizations to manage these networks. An individual plan, could be the largest plan, may have a hundred LHCSAs in their network.

What we believe is necessary in order for better patient care, greater safety, is to have some consolidation in this sector. And we think at the end of the day the

proposal, which gives the department discretion to work with plans to basically help them consolidate their networks, will lead to a safer, more cost-effective long-term-care system in New York State.

SENATOR HANNON: Commissioner, I -- there's a lot of little things and big things that I could bring up, but I want to address little things, and not specific. I find it dismaying that in the middle of the budget, $64 billion in spending, that we have to deal with minutiae of how to run long-term care, minutiae of licensure, of anesthesiology, items that are important in the long run for healthcare, but nowhere near big enough to be -- should be included in the budget.

And I simply think that all of those items, a number of others, should be excluded and dealt with otherwise. They used to be things such as program bills that would come from departments, maybe even Governor's proposals. We've seen none of those. And virtually over the past few years they've dried up. And that's where we ought to have

informed discussion, not in the middle of a $64 billion budget.

Senator Young?

CHAIRWOMAN YOUNG: Thank you, Senator Hannon.

I'd like to point out that we've been joined by Senator Patty Ritchie, Senator Roxanne Persaud, Senator Tim Kennedy, and Senator Susan Serino.

Chairwoman.

CHAIRWOMAN WEINSTEIN: Thank you. We've been joined by our Insurance chair, Kevin Cahill, and also Assemblywoman Pat Fahy.

And to our Health chair, Dick Gottfried, for some questions.

CHAIRWOMAN YOUNG: And also, I'm sorry, Senator Martin Golden, in the audience.

ASSEMBLYMAN GOTTFRIED: Okay. Good morning. I have a couple of questions for Dr. Zucker and then a few for Mr. Helgerson.

But before I do, I just want to say I've jotted down and I might see if I can

have somebody embroider it, "When did the health and well-being of New Yorkers become negotiable?" I think that's a phrase we can all use.

And you mentioned Hermann Biggs, and it just reminds me of one of the things that Dr. Biggs said, which is "Life expectancy is purchasable." Something else we all need to keep in mind.

So a question about Early Intervention. For years the state has been trying to squeeze more than -- more than about $15 million a year out of insurance companies, with no success. And 60 percent of non-government health coverage is delivered by employer self-insured plans that New York State cannot regulate.

The Executive has proposed putting all sorts of obstacles in the path of EI providers as part of this effort to get blood from a stone. Why not just tax health plans as a group $15 million, more or less, and tell them they're off the hook for covering EI services? We'd get the same money and we

wouldn't have to torture EI providers and pay millions to a fiscal agent.

COMMISSIONER ZUCKER: Thank you, Assemblyman.

Let me mention a little bit about the EI program. I've looked into this since last year when we were talking about this, and a little bit about the state fiscal agent. And what we found is that since 2013, the state fiscal agent has processed about $3 billion in provider claims, and 99 percent of those claims actually were fully adjudicated and paid relatively quickly.

And there are some challenges. The -- also, the state fiscal agent has been able to initiate reimbursements for the state's share of 49 percent through vouchers. The statewide proportion of the claims submitted to the commercial insurers that are reimbursed has doubled. It was originally 10 percent, and now it's about 18 percent. It was a little less than 10 percent.

The point you bring up is, you know, the question is how much does one charge the

insurance companies for something of this nature. And that is one issue that could be raised. But I do believe that the fiscal agent has been doing what they've been charged to do. And granted, the amount of reimbursement, it would be nice to see more of a return from the amounts that we've seen, 18 percent. But I think we're moving in the right direction on this.

ASSEMBLYMAN GOTTFRIED: Is that 18 percent of all claims were referred to insurance companies? Or that 18 percent of the EI program is paid for with insurance dollars?

COMMISSIONER ZUCKER: I think it's the claims, but I will check.

ASSEMBLYMAN GOTTFRIED: Yeah. Because I don't think there's been significant growth in how much blood we get from that stone, which to me is the number that matters.

Second question. Two years ago the Legislature accepted the Executive's demand to cut a broad range of public health programs by 10 percent. Last year we

accepted the Executive's demand to cut them another 20 percent. Now the Executive is demanding another 20 percent cut, although a handful of the programs have been spared a third round of cuts.

What is the justification for cutting these programs yet again?

COMMISSIONER ZUCKER: Well, I think the issue here is that we're trying to make the system as efficient as possible. And there are programs where, within the state, there's funding coming from different parts of the department, and we're trying to work to streamline that.

And I recognize that this was raised before, regarding consolidating some of these programs, but we do believe this will be in the best interests of not only the community and those who we serve, but obviously much more fiscally responsible.

ASSEMBLYMAN GOTTFRIED: Well, the question I asked isn't about the lumping together, although I assume we're going to reject the lumping part for a third time.

Why the 20 percent cut? How is that -- I mean, is there less need for the cancer programs, is there less need for the other 30, 29 programs in the --

COMMISSIONER ZUCKER: Well, it's not that. It's we've looked at the numbers to figure out where -- how can we make this more efficient and bucketing different areas. And as I was mentioning before, that there are certain programs or topics that we address that are being funded by different parts of our department, and that's how we came up with that number, looking at where we could -- if we consolidated some of these, it would probably be about 20 percent savings.

ASSEMBLYMAN GOTTFRIED: Well, since you knew -- or since you know that we're going to reject the lumping, why after three years don't you just submit a budget that tells us which programs you think are overfunded and then we can respond?

COMMISSIONER ZUCKER: Well, it's not so much overfunding, it's funding that -- as I was saying, that we're funding it in

different areas and that we can probably pull this together more efficiently.

ASSEMBLYMAN GOTTFRIED: So if they're not overfunded, they should get the same level of funding?

COMMISSIONER ZUCKER: Well, there's also other costs that go into this. And I guess the answer there is how do we become more efficient on this.

But I'd be happy to get back to you and to your team specifically about which areas and how much money that we see would be saved as we put different areas into the buckets.

ASSEMBLYMAN GOTTFRIED: Well, I think after -- now that we're on the third year of this, I think we'd welcome seeing that.

I have a few questions for Jason Helgerson.

So Senator Hannon touched on the nursing home being moved out of MLTC question, and I want to approach that with a slightly different angle. We know that many managed long-term-care plans really do not

like being saddled -- I would say all of them, maybe, do not like being saddled with high-need home-care patients, in part because they don't get adequately reimbursed for -- or they don't get extra reimbursement for having high-need home-care enrollees.

And my concern about the nursing home provision is that you are telling MLTCs that if they can move a high-need home-care patient to a nursing home -- and there are ways to make that happen, not entirely consistent with the will of the patient -- but if you can move them into a nursing home, in six months they'll be off your books. And so that gives an MLTC an enormous incentive to unload their high-cost home-care patients into a nursing home, knowing that in a few months that person, who is now institutionalized instead of living in their home, will be off their books.

That seems to me not only cruel to people who want to remain in their homes, but contrary to what we have for many, many years in New York said is our policy of trying to

keep people in their homes.

DIRECTOR HELGERSON: Well, I would say that for many, many years the policy in managed long-term care was that the nursing home benefit was not part of the benefit package. So that the managed long-term-care plan had the incentive, prior to the carve-in, that if they had a high-needs individual, they could simply get that individual off their books, as you put it, by encouraging that individual or helping that individual enroll in a nursing home.

So I think that the move in moving the benefit into managed care, the nursing home benefit, addressed that core concern.

What we're saying here is that this is an individual who they and their family have decided that the nursing home is a permanent placement, that it is the place that meets their needs on a go-forward basis from that point, and then six months after that. So if there's a change that somebody has determined -- or that individual has changed their mind, that they'd like to move to the

community, we give that additional six-months opportunity for that sort of change of heart.

And we're also looking at the possibility of reconfiguring the managed-long-term-care quality pool to actually create stronger incentives around and rewards for relocations. So individuals who for whatever reason are in a nursing home for a period of time, to incentivize the plans to relocate.

But I still think that the policy is clearly superior to what it was prior to the carve-in. But I do think what it does is that it ensures that we're only paying that care management fee once for individuals who are in essence electing to stay in the nursing home on a permanent basis.

If an individual at any point decides that they want to relocate back into the community, they have the opportunity to re-enroll in a managed-long-term-care plan and then the state and the plan will work together to try to find a community placement for them.

ASSEMBLYMAN GOTTFRIED: Well, of course the problem is after they've been in a nursing home for six months, more than likely they have no home in the community to go back to. And when they were being shipped off to the nursing home, it was probably likely that they had little or no social supports in the community to help them resist being shipped off to a nursing home.

And so while this situation may not be as bad as it was before the nursing home benefit was included in MLTC, you're taking a significant step back to those bad old days.

DIRECTOR HELGERSON: So I appreciate that. I think the policy objective here is to institute a policy where if a person has chosen, in consultation with family, and healthcare professionals have chosen that ultimately that the nursing home is the appropriate place -- and obviously there are tens of thousands of people in New York State who are in nursing homes, many of them, the majority of them, appropriately so -- that in those cases where it's a long-term stay, that

we just are saying we don't want to pay for the care management twice.

But what we do want to do is give maximum opportunity for relocation. And -- this is an important point -- if someone decides at that point, at any point after they've been in a nursing home that they want to relocate, we are going to create the option for them to enroll, at their discretion, in a managed-long-term-care plan and then have the opportunity to then work with that plan and the state to look at alternative settings outside the nursing home if that's what they so choose.

ASSEMBLYMAN GOTTFRIED: Yeah, except we've agreed that they don't have a home to go to.

Let me ask you about the Traumatic Brain Injury program, because the department is still committed to forcing patients in the Traumatic Brain Injury Program into managed care. The patients, their service providers and the managed care plans all agree that this is a bad idea. The current program

meets DOH goals of care management and fiscal efficiency.

The only argument I've heard for the change into managed care is that we must adhere to the doctrine of managed care for everything. If the managed care doctrine doesn't have to apply to nursing home care -- or, by the way, to people who have a UAS score of less than 9, whatever that means. So if that doctrine doesn't apply to those categories, why must it apply to the TBI program?

DIRECTOR HELGERSON: I think at the end of the day we've been working with a diverse group of stakeholders on that particular transition. We know that it's a sensitive one and that there's concerns about the types of services and unique nature of the waiver programs going forward. We still think, at the end of the day, it's best served as part of the service array within the managed-care context.

What we're interested in as we've migrated lots of services and populations

into managed care, we're always looking to make sure that our policies are appropriate. Not every single population in the program is currently scheduled to move into managed care, and it wasn't from the beginning. We said the vast majority of those services were appropriate for managed care and populations and services were appropriate for that, but I think we always said as we moved forward we would look at the evidence, look at the experience and adjust accordingly. That's why we're proposing the change in the case of the nursing home.

Which as I say, if we had a better relationship with the federal government relative to collaboration on Medicare and Medicaid, at this point I think we'd be having a different conversation about the nursing home change, so -- but that is what it is.

But our hope is we can work with the stakeholders still on the TBI population and see if we can't find a pathway that, you know, works for all affected parties.

ASSEMBLYMAN GOTTFRIED: So for several years we've been asking about this. For several years the department has been saying "We think it's best." I assume, in all that time, the department has thought through several ways in which it is best to move TBI patients into Medicaid managed care.

Could you in the next couple of days write down in a little -- in more than four words why it's best and send that to me?

DIRECTOR HELGERSON: Absolutely. Happy to do so.

ASSEMBLYMAN GOTTFRIED: Okay. Because I don't think we've heard more than, Well, it's best.

The Executive proposes -- and Senator Hannon asked about this -- to require MLTCs to restrict their provider networks to no more than 10 LHCSAs. Why is this a good idea? If we want MLTCs to restrict their provider networks -- contrary to what we urge all other managed-care plans to do -- so if we want them to restrict their provider networks, which I don't accept, why can't we

trust MLTCs to do that on their own?

DIRECTOR HELGERSON: Sure. So MLTCs have tried in the past to restrict their networks. The issue is is that given our policies relative to the ability of individuals to switch plans at any time, when a plan attempts to restrict its network, the provider affected by that restriction can communicate to the member that this restriction is coming and then basically encourage the person to switch plans.

And that's always been an inherent threat that's out there that a provider has against a plan, is that if I'm excluded from your network, I will take my members with me. And that has made it very difficult for plans to do something which we think at the end of the day is in the best interests of the program, which is rationalizing the network.

It's very difficult for a plan to chase after large numbers of small agencies who are providing some of the most important, most personal services that exist in the full Medicaid array. We have concerns about the

health, safety and the quality of those services as provided by these very small, mostly for-profit entities, and we think consolidation into a smaller number of agencies will enhance patient safety, improve quality, and support the overall efforts of the program. And given the way the program is structured, it's very difficult for the individual plans.

I would also mention we have an interest in consolidation in the managed-long-term-care space as well. There's lots of different plans. So we're interested in consolidation at the plan level as well. But we think at the end of the day that consolidation will lead to, as I say, a safer, more effective system and program for the Medicaid population who relies on these services each and every day.

ASSEMBLYMAN GOTTFRIED: Okay. I'll come back later with a couple more questions.

CHAIRWOMAN WEINSTEIN: Before we go to the Senate, we've been joined by Assemblyman James Skoufis.

CHAIRWOMAN YOUNG: Thank you.

I'd like to start with some questions about the transportation-related Medicaid proposals that the Governor included in the budget. And so the Executive proposes legislative and administrative actions to transition the facilitation of Medicaid transportation away from the purview of healthcare plans to a statewide transportation manager. The Governor anticipates that this will result in savings, arguing that the manager is a more efficient means of facilitating the transportation.

As you know, Mr. Helgerson, members of our Senate conference have expressed a lot of concerns over the years over this statewide Medicaid transportation system. I think I've shared with you horror stories of people from Buffalo coming down, driving 50 miles to take somebody to a medical appointment, and then driving back to Buffalo. I really can't see how that saves the state any money.

And on top of it, we've lost local control. And locally, people know better how

to get people to appointments, especially in rural areas, than a statewide manager.

So the Governor proposes a combined $20 million in transportation-related savings initiatives, three of which directly relate to the transportation manager. There's a carve-out for -- from the Medicaid long-term care for 6 million, adult day healthcare carve-out for 7 million, and the elimination of rural transit assistance for 4 million.

Now, just to give you a flavor -- I'm not overblowing this at all. I want to give you a flavor of what we deal with, for example, in my district. This is an email sent to me by the director of one of my Offices for the Aging in my district.

"February 8, 2018. Dear Senator Young, our office has been trying to help a seriously ill elderly man on Medicaid arrange rides to his needed appointments. Unfortunately, MAS -- the statewide system -- has failed him many times, and he has been missing his life-saving appointments." The full details of this issue are outlined in

the email which I'll read from in just a moment.

"I'm calling your attention to this particular case, but it is by no means an isolated incident. Our volunteer coordinator who arranges the volunteer transportation for non-Medicaid clients is spending more and more time trying to fix problems MAS has created for our clients."

So I think this is a very compelling story. The patient is 75 years old, had heart surgery, and is required to go to the cardiologist at the hospital for life-saving transfusions of antibiotics because he has a blood infection.

So on February 1st, his ride did show up and he received his treatment. On February 2nd, he was getting reoccurring calls saying that a driver was coming, and the driver showed up at 7 p.m. for a 2 p.m. appointment. The driver from the Yellow Cab service told this client that he was doing him a favor and wanted extra money for it.

The driver took the patient to the

hospital to get the antibiotic treatment, and when they arrived at the hospital, the driver requested gas money from the patient. After the treatment was completed, the driver took the patient home, and at his residence the driver told the patient that he wasn't going to let him out of the cab until he got money. The patient told him that he would kick his window out if he didn't let him out of the cab, so the driver finally let him out.

On February 3rd, February 4th, February 5th, no driver showed up for the transport to the daily treatment for his blood infection. On February 6th, the patient called the Office for the Aging and spoke with a volunteer coordinator because he needed a ride and he was very frustrated.

There are a lot of descriptions here about waiting on hold to MAS for very long periods of time, the person on the other end of the phone being very rude when they tried to get to the bottom of it.

And I think that this is just a prime example of why the statewide transportation

system is not working. Could you please address that?

DIRECTOR HELGERSON: So obviously it's a program now that serves millions of individuals. I'm not familiar with the case you describe. It certainly sounds like a horrific set of circumstances. Happy to look into it.

We take any complaints, issues raised about the performance of either the transportation manager or by the individual transportation provider. So it sounds like part of the issue there was the cab company in particular. We will be more -- happy to look into those.

Overall, we feel like overall transportation, the number of rides being provided, is up, yet we're saving somewhere in the range of I think about $90 million a year compared to what our transportation costs were prior to the implementation of the manager. So we think they're very cost-effective. But -- so as a result, as I say, happy to look into the circumstance, but

overall we feel that the transportation manager has been a very successful program.

CHAIRWOMAN YOUNG: Well --

COMMISSIONER ZUCKER: Senator?

CHAIRWOMAN YOUNG: Yes.

COMMISSIONER ZUCKER: I just want to add something on this, because this is -- this goes back to the bigger picture. I feel for -- I really feel for this person. And upstate New York is challenging, and even in the city it's challenging. And for those who are elderly, it's really tough.

But I think it also touches upon some of the other things we're doing in the department. The regulatory modernization initiative is to look -- and I know you've been very interested in the issue of telehealth. And perhaps there are ways, as we move forward with our RMI, to get our regulatory program in line with how clinical care is being provided that individuals like this gentleman, who clearly was struggling with the system, would be able to get some of that care perhaps without even having to take

that ride.

And that's something which is really important. Because believe me, as a child of parents who are elderly, asking them to go to the doctor and picking them up, and particularly in the winter, and then bringing them back is a big ask, and the risk of them getting sick is also great as well. So I hear what you're saying.

CHAIRWOMAN YOUNG: Well, I appreciate what you're saying too. But even though you serve millions of people, it's still no excuse for these types of instances. And Senator Krueger just turned to me and said, "We should ask the legislators in the room if you've had problems with the statewide transportation system, raise your hands."

Because this is not just limited to my district. And under the old district with the local control, something like this never would have happened.

So I think the point is you are serving millions of people every day, and it's not working because it's just too large.

We are not a one-size-fits-all state. As you look at Cattaraugus County versus the Bronx or Saratoga County, they're -- all different areas of the state are very different. They have different needs, different populations.

And so what I'd like to know is, what do you foresee will happen to the role of public transportation providers if this $4 million in supplemental funding is taken away? I mean, for me, this is going in the wrong direction. We already obviously have a problem, and it's not being addressed satisfactorily, and now there's a cut to the program.

DIRECTOR HELGERSON: Sure. So that -- just to give a little history about that $4 million. So that $4 million was in essence supplemental. It's not a Medicaid payment, it's not for Medicaid-related services.

One of the issues that when we created the transportation manager we found was that counties were in essence billing Medicaid inappropriately, and that Medicaid was paying

a far higher share of local transportation costs than it should have under any scenario.

So as a result, as part of the transition away from that financing system to a statewide system where we were billing particularly the federal government appropriately, that we in essence provided the funding to those targeted counties. And so the budget proposal -- we always saw those as a temporary transition. It's now continued on for a few years. But at the end of the day, the proposal is is -- the assumption is is that those local transportation non-Medicaid services should be paid for through ways other than through the Medicaid program.

CHAIRWOMAN YOUNG: Thank you. I do think we have a serious problem here in New York, and we have to reevaluate the entire system. And our recommendation -- at least mine would be go back to local control. Local people now how to run local networks. And when you have this mammoth statewide network, these type of horror stories are

happening.

I'd like to ask about the Medicaid global cap. And so in the Governor's budget it projects the Department of Health state Medicaid spending to be $20.6 billion, which is an increase of $1.2 billion, or 6.3 percent, over fiscal year 2018. Which actually exceeds the global cap.

Of the total $1.2 billion growth in Department of Health Medicaid, $630 million is attributable to spending increases that are excluded in statute from the global cap calculation. And these include state takeover of local growth, minimum wage and Medicaid administration. And so I had a few questions on that.

First of all, do you believe the global cap is truly working as first designed if non-DOH Medicaid expenses are allowed to be shifted into the global cap just to achieve the financial plan relief?

DIRECTOR HELGERSON: I think the global cap has been a tremendous success for New York. It has provided much greater

transparency. It has made it very clear to the Health Department that we have a fiduciary responsibility to manage the program. We manage it very aggressively, and I think that has been a boon to New York taxpayers as a result.

Per-recipient spending in the Medicaid program is now less than it was in 2003. And I would say you'd be hard-pressed to look nationally for programs that have performed as well as we have in terms of reducing per-recipient spending.

When we started Medicaid redesign in 2011, I think there were about 4.6 million people on the Medicaid program. There are now 6.6 million people on the Medicaid program. And so we've been able to live within very modest growth linked to the medical portion of CPI throughout that growth period. And the only way you make that work is reducing your per-recipient spending. And I think that the global cap has been extremely helpful in that regard.

I think also the two-year

appropriation structure has given us some certainty and allowed us to plan for the longer term. And I think that that has also benefited taxpayers and Medicaid recipients in a significant fashion.

As to the transfers out of the global cap to the General Fund each year, we've made contributions to the General Fund in varying amounts. I think that one of the great global cap success stories was when the state faced the largest disallowance from the federal government in the history of the Medicaid program, which associated with the change in a 20-plus-year-old funding policy for services for people in the OPWDD system, that the global cap was basically able to find savings sufficient to make up for the vast majority of those -- that loss of federal revenue. It was a loss on a go-forward basis of a billion dollars, and basically we were able to do that without taking a single benefit away from a single New Yorker.

And I think that it's -- the

discipline, the structure created by the global cap has really been, as I say, good for New York Medicaid recipients but also good for taxpayers.

CHAIRWOMAN YOUNG: So thank you for that answer. And you just went into a long answer about why you think it's working. But if that's the case, then why put non-DOH Medicaid expenses into a mechanism that is designed to limit only DOH Medicaid spending?

And also, if it's working as designed, why did the Executive Budget offload a Medicaid program, the Value-Based Payment Quality Incentive Program, into the Essential Plan, which seemed to be done just to make room under the cap for the non-DOH Medicaid expenses? Could you specifically answer those questions?

DIRECTOR HELGERSON: Sure.

So in the case of the VBP QIP program, the Value-Based Payment Quality Improvement Program, which is designed to support our struggling hospitals move into value-based arrangements and restructure themselves so

that they can sustain their operations and sustain access to healthcare in their communities, that program is, under this budget, proposed to shift to the Essential Plan.

I think what's important to point out about the Essential Plan is the Essential Plan in essence backs up into the global spending cap. It generated tremendous savings for the global cap when we implemented the Essential Plan. But what we're always looking at is finding ways to reduce reliance on state funds, increased reliance on federal funds, and that's in essence why we did that shift.

As I say, I think it's a smart, practical, efficient use of funds. The plans that participate in the Essential Plan are exactly the same plans that participate in the Medicaid program. So from a hospital standpoint, from a plan standpoint, it's going to be a pretty seamless transition.

And as I say, it's a way for us to deal with cost growth in the program without

having to go to taxpayers for higher taxes or to cut the benefits to the program recipients.

CHAIRWOMAN YOUNG: So you brought up a former case with OPWDD just a moment ago. How do you justify the machination of using federal funds in the Essential Plan to pay for Medicaid programs which may set the state up for another investigation related to improper use of federal dollars and actually an eventual clawback?

DIRECTOR HELGERSON: Actually, there is no threat, in our view, at all from this shift whatsoever. We've communicated it, I think, to your staff as well that actually this shift -- these programs were approved under Medicaid. There's no reason why they can't operate under the Essential Plan. In fact the level of federal scrutiny under the Medicaid managed-care rates is even higher than it is under the Essential Plan rates. So these rates, these programs have been approved by the federal government under Medicaid. We don't see any reason whatsoever

why they wouldn't and can't exist under the Essential Plan.

CHAIRWOMAN YOUNG: Thank you. I have more questions, but I'll give it over to the Assembly.

CHAIRWOMAN WEINSTEIN: Now we go to Kevin Cahill, our Insurance chair.

ASSEMBLYMAN CAHILL: Thank you, Madam Chairs.

Dr. Zucker and Mr. Helgerson, thank you for coming today. And I -- you know, we oftentimes forget that the two parts of the budget that really make up the bulk of it is healthcare and education. And my colleagues just commented to me off the mike that it's interesting, we never hear anybody in education talking about reducing the cost of education. Per student, yeah. We're content with the idea of improving education for every student. But we seem to have many times gotten away from the quality aspects when we come -- when it starts to come to budgets when it comes to healthcare.

I want to start with Early

Intervention. In the exchange with Chairman Gottfried, Dr. Zucker, you indicated that you believe that the fiscal agent is doing what they were intended to do, what we expected them to do. So I have very specific questions about what the fiscal agent has done.

How much have we paid them since last year when we had this discussion, and how much have we paid them overall? I'll ask you all the questions, then you can just respond. How much more are insurance companies paying as a percentage before we had the fiscal agent to now, and how much more as a matter of dollars since before to now? And how much faster and easier are providers getting paid compared to before and now?

So those are the general questions that I have on the fiscal agent. They're very similar to the same questions that I asked last year. And then I just have this other very technical question, is do we have a contract with the fiscal agent in effect today? I know we did for several years, and

we were committed to paying them several millions of dollars. There was some portion of the contract that was outcome-based. So the questions are, how are they doing their job specifically to answer those questions, and whether we are acting under a contract.

COMMISSIONER ZUCKER: So on the specific amounts, I will have to get back to you on the specific amounts that we have.

From July 20, 2013, to December 2017 was a total $88.5 million in billed in the Medicaid sweep, and $65.4 million, or about 74 percent, was paid in that window of time. And I have -- there are more details; I can get that for you on the exact amounts on that.

In the most recent six-month period, 95 percent of the provider claims were fully paid within two months. But I have to find the exact number for you on that.

ASSEMBLYMAN CAHILL: So it's been proposed that we increase the fines on the insurance companies for whatever administrative shortfalls they have in the EI

program. Is there any evidence that they're not meeting their administrative responsibilities under the program, that there's a need to create greater disincentives to not comply?

COMMISSIONER ZUCKER: Well, I think the thing here is that we're trying to -- part of this is obviously insurance companies. I believe the fiscal agent has been doing what we charged them to do. The issue here is I'd like to see more of the insurance companies step up a little bit more to the plate on this issue.

ASSEMBLYMAN CAHILL: But what the fiscal agent was charged with doing was increasing the percentage of claims that were going to be paid by insurance companies and easing the processing of claims. And every report I get is that we are the same or a little lower in terms of the percentage of claims, and that it is more difficult -- in fact it is consuming one-third of the time of providers to pay these claims.

So I'm very interested in hearing how

your assessment is that they're doing the job we told them to do when every indicator that I have from when this was first proposed is that we're not. But I'll wait so you can send me something on that.

Healthcare generally. Should we have an individual mandate at the state level, since the federal individual mandate seems to be going by the wayside?

COMMISSIONER ZUCKER: So are you asking on just a -- I'm unclear with what your question is.

ASSEMBLYMAN CAHILL: Well, the federal government -- the Congress recently, as part of the tax reform, curtailed the individual mandate; that is, that required every individual to have insurance or pay a tax fine, essentially.

And my question is, should New York State supplant -- should New York State, as some states have chosen to do, have an individual mandate requiring every New Yorker to have insurance?

COMMISSIONER ZUCKER: Well, I think

that what we do have is that what we are working on is decreasing the number of people who are uninsured. And at this point in time we've gone down from what was at one point 10 million down to 4.7 million with our New York State of Health. And so between that, between the Medicaid program with the 6 million individuals covered, I think that we've done a successful job in getting people covered.

Obviously there was a challenge with the ACA, but -- and the federal government, I should say. But we have made a significant progress, particularly with the State of Health, with the exchange. And even in this past year we've had hundreds of thousands of additional people added.

ASSEMBLYMAN CAHILL: So are you anticipating any change in that response when the individual mandate goes away?

COMMISSIONER ZUCKER: When the individual --

ASSEMBLYMAN CAHILL: When the federal individual mandate goes away.

COMMISSIONER ZUCKER: I think that we'll continue to be able to move forward and get as many, if not all, New Yorkers covered.

ASSEMBLYMAN CAHILL: Okay, thank you.

I'd like to move to the Governor's proposed health tax of 14 percent. Are you at all concerned from a public health perspective about the impact on consumers where -- you know, whether benefits will be curtailed or whether premiums will be increased? And also the pressure that will bring to providers. Will insurance companies looking to make up that money then go back and seek reductions in what they're paying providers who are already strapped? Are you perceiving any issues with that in terms of the Governor's 14 percent health tax?

COMMISSIONER ZUCKER: So the 14 percent tax is going on the insurance company. If we look at this, actually the insurance companies are getting money back from the government. And so that 14 percent that we are taxing is not money that will end up being passed on -- I hope that doesn't get

passed on, because that's additional money that the insurance company has gotten from the federal government. And we feel that that money, the tax to us, will help improve healthcare to the people of New York.

And so it's not like there's an additional charge to the insurance companies where they have to somehow recoup it. They've gotten money from the federal government.

ASSEMBLYMAN CAHILL: So because they, like every other corporation, will see a reduction in their taxes from 35 percent to 21 percent or whatever the numbers are, it's perceived that this would be a wash for the insurance companies and that they wouldn't pass it on?

COMMISSIONER ZUCKER: Well, we would not want them to pass it on.

ASSEMBLYMAN CAHILL: Well, we don't want them to, but the question is will they.

COMMISSIONER ZUCKER: Well, we'll sit down and talk to the insurance companies. And I'm sure this is a question for other

parts of the administration also --

ASSEMBLYMAN CAHILL: So I want to talk about the Governor's 2 percent opiate tax. And this is a slightly different question.

The problem we have in my community and the communities in -- many of the non-urban communities is that people that have an opiate problem self-transition to illegal drugs. They transition to heroin because it is already less expensive than prescription opiates. The Governor's proposal would increase the cost of prescription opiates. Are you at all concerned that we're going to be driving more people to heroin because legal opiates will become more expensive?

COMMISSIONER ZUCKER: So I think a couple of things about this tax. Number one, we are working with the communities, particularly other -- well, let me start by first saying that we believe that the way this is designed is at a high level, so the tax would not end up being passed down to the consumer.

But I think there's a bigger issue here. When you look at this issue of opioid addiction -- and unfortunately, as a doctor, I have seen this. I have seen colleagues who have been -- unfortunately who have died as a result of opioid addiction. I personally actually years ago tried to resuscitate one of my own colleagues in the hospital who was addicted to opioids.

And the pharmaceutical companies -- and I also do see, when they're used the proper way, particularly fentanyl, it is helpful for those -- I'm an anesthesiologist -- helpful for patients.

But that being said, this has become a major problem in the country and we have lost thousands of people in New York State. I hear the stories, I'm sure all of you in the Legislature have heard the stories. And we feel that this tax, the money that will come from that tax will help prevention, it will help in treatment programs. And the pharmaceutical companies, even they themselves have said, if you read about it,

that they did not provide -- they weren't so transparent on the potential addictive qualities of particularly Oxycontin and others.

So I think that it behooves us as a state to do what we can to solve this problem. And the Governor is committed to this, and he's been all over the state talking about it.

ASSEMBLYMAN CAHILL: I'll leave the rest of my questions to my colleague Mr. McDonald, who's indicated that he has questions on that score. And on a similar note, I will defer to my colleague Senator Serino to talk to you about Lyme disease. That's also on my agenda.

I want to close, and with 23 seconds left, just ask you a little bit more about Wadsworth. If you were to get the $600 million in this year's budget for Wadsworth, how long would it be before we would see a modern state-of-the-art laboratory back in New York State that would be competitive on a national scale, as it was

before?

COMMISSIONER ZUCKER: So I think two things. One is the competitive nature of Wadsworth on a national scale, they're second to none from the science standpoint and from what they provide. And I will tell you that the CDC has turned to us, New York State, when we had the Zika issue, and other issues as well in the past four years, at least during my tenure, saying that: You have Wadsworth, and you're able to provide the services that the rest of the country doesn't have the opportunity to have. So that's on the clinical front.

From the standpoint of the actual physical plant, we will move forward as quickly as possible to develop a lab. There's so many components to the Wadsworth state lab and what needs to be done to make sure that this ends up being a state-of-the-art lab that provides for public-private partnerships and is innovative and will move forward for the next century to come. Wadsworth celebrated its -- over a

hundred years, as I mentioned, a little while back.

So I can't give you an answer exactly how soon, but I will tell you it will be quick, because that's what my goal is and the Governor's goal is as well.

ASSEMBLYMAN CAHILL: Thanks, Dr. Zucker, Mr. Helgerson.

CHAIRWOMAN WEINSTEIN: Thank you.

CHAIRWOMAN YOUNG: Thank you. Senator Valesky.

SENATOR VALESKY: Thank you, Madam Chair.

Commissioner, Mr. Helgerson, thank you for being here today and thank you for the fine work your department does.

I just wanted to touch on one general area, following up on Senator Hannon's comments earlier. It appears that as we speak this morning, over at the Capitol the budget director is presenting some of the Governor's thoughts in regard to 30-day amendments, which I believe are due to the Legislature later this week.

One of the items -- and I'm reading from one of the reporters covering the activity over at the Capitol -- legislation will be introduced or sent to the Legislature by the Governor to create two charitable contribution funds to accept donations to fund healthcare and education programs.

Can you tell this panel what healthcare programs the Governor is proposing to be funded through this new charitable contribution fund that's being, I guess, unveiled this morning?

DIRECTOR HELGERSON: Sure. I think it would probably be best to direct those questions to Budget Director Mujica. But I would say that the Governor has been pretty clear about his concerns about the implications of the federal tax changes. And I know the Governor and the budget director and the Department of Tax & Finance have been working around the clock looking at any and all opportunities.

Healthcare and education are the two biggest things that state government does, so

I don't think we should be surprised, as they are rolling out the Governor's proposals on this important topic of how do we raise the revenues necessary to support state government with the least tax burden on our taxpayers, that healthcare and education be part of that conversation. But as to the specifics, I think you really should direct those to Mr. Mujica.

SENATOR VALESKY: Thank you.

Senator Hannon detailed a number of the changes that just came about late last week from the federal government in regard to DSH and the Child Health Program and several others. My understanding is that that may in fact result in an approximately $4 billion positive impact to the State of New York that was unknown at the time this budget was submitted to the Legislature.

So my question is -- the shortfall fund that is also part of that budget, I believe, would raise about a billion dollars. I guess the question would be, where is the continued need for a shortfall fund if in

fact the actions taken in Washington late last week would seem to make that shortfall fund unnecessary?

DIRECTOR HELGERSON: Yeah, I would say basically, I think, what I kind of said earlier, which is that at the end of the day there's still a tremendous uncertainty. I mean, the president's budget coming out today clearly signaled as recent as last night that there's going to be significant cuts in spending, discretionary spending outside of the military. We have to wait and see what those are, see how that federal budget process works its way through.

I don't think we should remotely think for a second that we are out of the woods relative to what Washington has in store for us. There are still majorities in both houses of Congress and the president who have stated that they support a move not only to repeal the Affordable Care Act but institute block grants in Medicaid, which our estimates show that at full implementation the loss of federal monies to the State of New York are

in the range of about $10 billion per year.

So those threats remain and are real. We certainly are pleased with what's happened relative to the Affordable Care Act debate, and we're happy that the most recent two-year agreement gives us a little bit more certainty on things like CHIP, which we didn't think should be remotely debated in this country anymore, but was. But I still think there's enough out there on the horizon that creates risk that justifies the Governor's construct. But obviously as we enter into our negotiations with the Legislature on the budget, I mean those will clearly be issues that we'll discuss.

SENATOR VALESKY: One other issue I just want to touch on.

I and I know many of my colleagues on this panel who represent rural hospitals are often concerned with their financial viability. There was legislation that was approved unanimously or near unanimously in both houses of the Legislature last session. I believe the Governor vetoed that bill to

address the issue of safety net hospitals and the definition of safety net hospitals, sole community providers as well as critical access hospitals being included in that definition.

Can you identify as to whether this budget addresses the issue as well as the Governor's concerns that he raised in that veto message? And are we going to correct this definition once and for all as part of this budget?

DIRECTOR HELGERSON: Sure. I think the Governor's budget, which you mentioned earlier the uncertainty about DSH, which was very sort of front and center in his mind as he prepared the budget, you know, and his desire to create this fund, in essence, to support any potential shortfalls -- in the face of that, I think the idea about increased funding to targeted sets of hospitals I think is a little difficult to think and propose, particularly as we didn't know exactly how the cuts would come and what form they would take and who would be

impacted.

But obviously we fully anticipate as we engage with the Legislature as part of the budget process, I'm sure this issue will come up, and we look forward to that engagement, particularly -- hopefully as more of the uncertainty that still hangs over us gets resolved, then I think we can look proactively at addressing some of the challenged sectors of our healthcare economy.

COMMISSIONER ZUCKER: And we have given capital grants across the state to many of the hospitals and many of the hospitals that have been challenged, particularly as -- some that you're aware of.

SENATOR VALESKY: And I hear what you're both saying. I think regardless of the uncertainty from Washington, there remains this issue, a statutory definition issue that we have tried to address in previous years as part of budgets, the Legislature clearly addressed in legislation late last session, again, that was vetoed.

So I might just suggest that

regardless of uncertainty from Washington, there's a basic issue of fairness here that continues to be an outstanding issue that needs to be addressed.

Thank you both.

CHAIRWOMAN YOUNG: Thank you.

CHAIRWOMAN WEINSTEIN: Assemblywoman Rodneyse Bichotte.

ASSEMBLYWOMAN BICHOTTE: Thank you, Madam Chair.

Thank you, Dr. Zucker, for being here. And I just want to thank you for all the work that you've been doing and also being a very responsive commissioner.

I have a lot of questions, but I will defer some of my questions to my colleague from Brooklyn on the issues of Downstate.

For now, I wanted to talk a little bit about my concern around the provisions allowing independent practice of nurses administering anesthesia without any supervision. And as I read it, the proposal will create a two-tier care system in my community where the quality of anesthesia

care will be determined by a patient's insurance and other economic considerations.

Now, you're an anesthesiologist, and I would not think that you would be pushing this type of practice. Shouldn't patients, regardless of types of insurance coverage or income, be provided the highest standard of anesthesia services by physicians that we have in the current state health code?

Also, let me just read this. In the provision that you have, it says that nurse anesthesia must be provided in collaboration with a qualified licensed physician. Listen to the key word: In collaboration. And that would mean the administration of anesthesia, anesthesia-related care to patients, pre-anesthesia evaluation and preparation, anesthesia induction, maintenance and emergence, post-anesthesia care, peri-anesthesia nursing, and clinical support functions and pain management.

I mean, I would think that you would want the person performing the anesthesia to have sufficient scientific clinical expertise

around that issue, as it's a very, very, very specialized area.

And please don't get me wrong; I am in full support of nurses getting more training and adding more functions to their workload, but under the supervision of a licensed physician for particular areas.

I also want to make note that in the definition of "collaborative," it means that -- it shall mean that the certified registered nurse anesthetist shall communicate with a person by telephone or through written electronic means, with a licensed physician qualified to determine the need of the service.

So to me, what does that mean? I mean, if I'm on the hospital table and I'm about to be operated on, does that mean that the CRNAs make a phone call or text a physician and they collaborate on the service right before I go into an operation?

So I do have a concern. And let me tell you, I'm going to just share a story of personal experience. I was pregnant a year

and a half ago when I was 43, and at 5.5 months I was at risk of losing my child, which I eventually did. And when I went to Columbia Presbyterian, which was a hospital that completely neglected me and sent me on my way, a community hospital in my neighborhood, Wyckoff, picked me up and treated me right.

And I will tell you, right there and then when I was experiencing excruciating pain, I thought I was going to die. I told my family "I'm going to die," because that's how I felt. And at that point I was looking for someone to help ease the pain, someone to help ease the pain, and the anesthesiologist was there.

Also at that experience I understood the real importance of safe staffing, because the nurses there really saved my life, and there wasn't enough of them.

So with all -- you know, taking this into respect, I think we really need to revisit what you and the Governor are proposing in terms of having not so much

trained nurses to perform the duties of the anesthesiologist without the supervision. We've got to think about that.

We've also got to think about opioid treatment as far as, again, trained unsupervised members of the healthcare are providing prescriptions, especially when doctors themselves are not trying to be involved in that area. It's an epidemic, it's a crisis. And that issue when it comes to opioid therapy, especially for chronic treatment, that typically is deferred to a pain specialist.

So we've got to look at all of this. And you being an anesthesiologist, I would have hoped that you saw the importance of quality care, how this can create a two-tier system, patients' rights, training, adequate training, the scourge of the opioid epidemic, and safety.

We want our patients to be safe. As my chairman had mentioned, of the Health Committee, the patient's care is not purchasable. It's not negotiable. It's a

human right. Thank you.

COMMISSIONER ZUCKER: Thank you. Thank you for your comments.

The issue of chronic pain, I think -- yes, as an anesthesiologist I recognize the challenges here. There are individuals who come in who truly have chronic pain. They have a condition that may be causing the chronic pain, or they may have had an operation and then as a result of that, they have a lot of chronic pain. And I do recognize there are specialists and subspecialists within anesthesiology who focus on this.

We in the department work closely with those in these specialties, and I have met with and spoken with anesthesiologists about this. When you mention the opioid crisis -- and as I was saying before, one of the challenges we're facing is that we've gone from a situation where the use of some of these opioids in a therapeutic setting has now -- particularly the fentanyl, and that's the real issue here in a lot of ways. And I

will bring back some of these fentanyl analogs that the Governor has gone after in a second.

But the use of fentanyl has been something which has its benefits in the operating room and in the other healthcare settings, but it's now on the street and it's something which is obviously causing many deaths. We work with our anesthesiology colleagues on how to make sure that those who have chronic pain can be managed appropriately. And I work with my anesthesia colleagues to talk to them about how can we address this opioid crisis given their expertise as well.

In December I presented at the PGA to the New York State Society of Anesthesiologists specifically about this, and I turned to my colleagues and asked, Help us as the department to move forward and provide us with some ideas of what you think we could do both as a government body but also what they can do as clinicians to resolve this problem.

So I'm happy to work with you and to work with those that are in the clinical setting to try to solve that problem.

ASSEMBLYWOMAN BICHOTTE: So you do agree that CRNAs should be supervised.

COMMISSIONER ZUCKER: So on that issue -- that was the second part. On the first issue, so I've worked closely with many CRNAs in my career, in many hospitals both in New York and elsewhere. The proposal is to have them be able to practice within their scope of practice.

But the proposal says that a qualified physician has to provide the oversight in any of these Article 28 facilities. And as a physician who has worked with CRNAs, that is one of the things they need, to have some -- there will be oversight by a physician. And that's what it's written as.

CHAIRWOMAN WEINSTEIN: Thank you. Thank you, Dr. Zucker.

Senate?

CHAIRWOMAN YOUNG: Our next speaker is Senator Gustavo Rivera.

SENATOR RIVERA: Thank you, Madam Chairwoman.

Good morning, folks. There's a couple of issues that I want to talk about. You just, in the end of that question, we started talking about the opioid crisis, so I want to go back through it. I am thankful that in many instances the Governor has shown, through his actions as far as policy, that he considers the opioid crisis to be a public health crisis and not a criminal justice one. I'm very glad that that is the case, and certainly many of my colleagues have come around to that. I am thankful that is the case.

But talking specifically about what is or is not in the budget, briefly, two things. First of all, as far as Naloxone is concerned, and the distribution of Naloxone that has happened to direct responders, what is currently in the budget? It seems to me that particularly what's -- as far as the funding that's in the AIDS Institute has been flat for the last couple of years. And I

know it's a tough budget year. But considering that this is the crisis that we're talking about, I wonder if you'd speak briefly about that, and there's another issue. But first, funding for Naloxone and providing it for first responders.

COMMISSIONER ZUCKER: So with the Naloxone, we've had -- 60,000 people have been trained about overdose -- on overdose responding. And last year we had about 9,000 reversals. This has moved forward. We are also working with those who have been incarcerated, when they come out, to train them about overdose prevention and offer them Naloxone kits as well.

So we are -- and so that's just two parts of it. We have worked with not only first responders but with so many other individuals to make them aware of this. I think a lot of this is an issue of education. The more educated the public is about Naloxone and just about overdose in general and about addiction, the better it will be.

I think that -- as I mentioned before,

unfortunately I have seen those who have overdosed and have treated them, and I think that the faster someone -- the more that someone understands and faster they respond, the better it will be for those.

SENATOR RIVERA: We agree. I just wanted to point out that again, I was referring to the funding and the fact that it remained flat for the last couple of years. So I would suggest -- certainly the 30-day amendments have already been presented. I have not seen them. But I would suggest that that be addressed and that we get a little bit more funding in that regard.

I wanted to ask quickly, because I only have a few minutes -- I have a couple of more issues, but on this, on the opioid crisis, there was a -- just a bill that was introduced just a week ago that dealt with safe injection spaces in the State of New York. And I know that there's a report that the City of New York Department of Health is putting together regarding that issue. There's many of us that support us

going in this direction.

Is there a position that the Department of Health has related to safe injection spaces? Or are you looking into it?

COMMISSIONER ZUCKER: So I am aware of what San Francisco and -- what San Francisco has done about safe injection facilities and also what Philadelphia has put forth or proposed. And so we're looking at that. We're looking at the pros and cons to that issue. And I'm happy to get back to you, but I'm keeping an eye on that topic.

SENATOR RIVERA: Please do. There's many of us that think it is a direction that we need to move in as far as policy if we continue to view addiction again as a public health issue and think about it as a -- how can we provide -- if we believe in harm reduction and we should expand programs in harm reduction, this is the next step. So I would suggest that that is something you look into.

I have a few more issues -- I might

have a second round. But I did want to ask about lead testing. You talked about it briefly in your presentation.

There is a lady by the name of Tiesha Jones who is the president of the Tenants Association of Bailey Houses, a NYCHA development in my district. She actually was the lead plaintiff in a lawsuit that was against NYCHA, and she won lawsuit. It was regarding elevated lead levels in her daughter Dakota's blood. Her daughter's name is Dakota. And she actually won that lawsuit a couple of weeks ago. But I wanted for you to tell us specifically, since that lawsuit was about improper testing and misinformation that was given to her by NYCHA, how would the proposal that the Governor is putting forward here make sure that elevated blood levels like those that were found in Dakota's blood, how would this proposal help to make sure that does not happen to any other child?

COMMISSIONER ZUCKER: So we have a very strong lead program in the state, and we track all cases. And if there is a child

whose lead level is elevated, we do go in there to look, to look at this.

I'd have to look a little closer, maybe after I can look into this particular case of Tiesha Jones and get a little bit more details and then get back to you.

SENATOR RIVERA: And I certainly think that would be important. This is something obviously that we have been talking about in the last couple of weeks, in the last couple of years, for some people. It is essential that we get it right. And if there is a way that this proposal could actually impact kids' lives in a positive way, I want to make sure that's the case.

I will come back for a second round, but thank you for the moment.

SENATOR KRUEGER: Thank you.

Assembly?

CHAIRWOMAN WEINSTEIN: Assemblyman Andrew Raia.

ASSEMBLYMAN RAIA: Thank you. I have a hodgepodge of questions from all over the map, so I'll try and do the speed round like

we did last year.

First, with respect to the Medicaid drug spending cap, the Governor is proposing to extend that. What type of growth are we predicting with that? I think it's 15 percent.

DIRECTOR HELGERSON: So I don't think we've yet projected out what the actual growth rate is. We're still I think working on finalizing what the managed care rates are going to be for next year, so we don't have yet a full projection. But the cap on drug spend is being proposed to continue for another year.

I would say overall the initiative has been very successful. So far the manufacturers have responded well. As we mentioned, the goal here was to avoid sort of open conflict and give manufacturers an opportunity to sharpen their pencils and submit rebate agreements that would bring down the net net price, and to a great extent that's exactly what manufacturers have done. We haven't had to actually refer a single

drug to the Drug Utilization Review Board for their consideration.

So we think that the signal effect has worked, and we think that we're going to be able to get through this fiscal year achieving the savings that was estimated without having to take a more formalized action.

ASSEMBLYMAN RAIA: All right. Because I mean all the studies I'm seeing are in the neighborhood of 5.5, 3.8 percent, nowhere near 15 percent. So if that's the case, then so be it.

Nursing homes. When was the last time they got a bump in the trend factor?

DIRECTOR HELGERSON: Well, many -- trend factor, we haven't really done trend factors in a long year time for any type of provider. We I think eliminated them pretty much back in 2011.

However, in the case of nursing homes, thanks to the universal settlement, virtually all nursing homes in the state got an increase in their reimbursement. It was I

think a huge win for the state because if you remember, we -- back in 2010-2011 the nursing home industry was on the verge of total catastrophe because of a change in reimbursement that hadn't been implemented that was going to create tremendous winners and losers. It was called rebasing at the time. And so we were able to weather that storm, implement a new financing system and, as a result of the universal settlement, were able to provide pretty much every nursing home in the state with some kind of increase.

So overall we think that nursing homes haven't had -- at least as far as, you know, compared to other providers in the program, have had a pretty good couple of years.

ASSEMBLYMAN RAIA: So they're not operating at a $61 a day -- let's see, Medicaid cost overall increasing -- they have a shortfall of $61 a day under Medicaid, don't they?

DIRECTOR HELGERSON: I'm not sure where that calculation comes in. But I can tell you that the consolidation in the market

and the fact that nursing homes are being purchased pretty rapidly whenever they come to the market I think is an indication that people feel that the nursing home industry in New York remains a robust business to be involved in.

ASSEMBLYMAN RAIA: Well, that's not what I'm hearing. Can you please explain the logic behind the 2 percent penalty attached to the nursing home quality initiative? It's my understanding that the lower 2 percent already are paying into the quality pool and not receiving funds back. It seems to me, you know, the fact that we're increasing money, you know, for safe hospitals and I would imagine most of the places where you would see this issue happening might be in underserved communities. So it almost seems like you're penalizing them for trying to do the right thing.

DIRECTOR HELGERSON: Well, actually we're penalizing them for doing the wrong thing, which is being really poor quality.

ASSEMBLYMAN RAIA: I understand. But

you've got to give them the means to try and lift them up, not penalize them.

DIRECTOR HELGERSON: I think what this is a good example -- I appreciate the question. I think this is a good example of us trying to put our money where our mouth is. In a sense it's saying we're going to use our payment policies to create incentives to improve quality, in this case for some of the most complex patients and complex individuals, most challenged individuals in our state.

And in this case the only way you get one of these penalties is if you get two consecutive years where you perform in the lowest quartile in the state or you went from having, in the fourth, the second-lowest into the lowest quartile in the second year. So you either have to be amongst the worst or moving into the worst categories.

And so I think this is going to create a strong incentive. It's a modest penalty overall, but we think it creates a financial incentive to improve quality and get out of

that bottom tier, which is ultimately in the best interests of the tens of thousands of people who are in nursing homes all across our state.

ASSEMBLYMAN RAIA: All right. I didn't get halfway there, but I guess we'll circle back. Thank you.

CHAIRWOMAN WEINSTEIN: Senate?

SENATOR KRUEGER: Thank you.

Senator Sanders.

SENATOR SANDERS: Thank you, Madam Chair.

Good to see you, Commissioner. Good to see you up here. When last we saw, you were down touring my district. It was very heartening to my hard-pressed hospital down there to see you and to see your commitment to the community.

I will return to my colleague's point. He pointed out the question of lead, and I want to return to that. It's a major problem, along with mold and lack of heat and hot water in my district.

Are you aware of what's going on down

in New York City, sir?

COMMISSIONER ZUCKER: Yes. Like you, I have been following this very closely, and I am very concerned. As a physician, as a parent, as a New Yorker, the situation there is worrisome, particularly for the health of children, the well-being of children there.

SENATOR SANDERS: Well, we -- just about everyone, I'm sure everyone is concerned on that too, sir. And I -- I have a lot of NYCHA buildings in my district. In fact, I was literally born in one of them. So I'm very concerned about what's going on. And we've had problems for a long time. Mold -- we live by the water, so mold is a problem and a very serious one.

What can the state do, what can you do, sir, about this problem that's in NYCHA? We need to have some type of resolution to the issue of mold, lead, heating problems there.

COMMISSIONER ZUCKER: So the state, as you know, has a long history of stepping up and stepping in when there are issues,

whether it's Legionella or Zika or other issues. Or even, for example, those challenges with some of the local health departments when we've had some outbreaks.

And so we've been looking at this very closely on this issue, and looking at what our authority is.

SENATOR SANDERS: Well, I'm going to -- I want to go a step further, since I have so many areas in my district. And all politics is local. Can you do random sampling in my district to see what the problem is?

COMMISSIONER ZUCKER: Well, we would need to look -- determine the scope of investigation and where specifically the Department of Health could be of assistance, yes.

SENATOR SANDERS: Well, sir, our need is so dire that I'm forced to be impolite. I'm going to have to say, what can you do today? What are you willing to do today to see what we can do about the problems that we're having?

COMMISSIONER ZUCKER: So, Senator, so if you're asking whether the State Department of Health can go in and investigate this, yes, we will do that. And we will sit down with you and with your team as soon as possible and move forward and look at the scope of this problem.

SENATOR SANDERS: Let me ask very directly, this is exactly what I need in my district. I need your team to come to my district to investigate and to see -- and my district, of course, is just a microcosm of everything. But all politics is local, let it begin with me.

COMMISSIONER ZUCKER: Well, I had an opportunity to be out in your district, as you know. And yes, the state will come in and investigate this.

SENATOR SANDERS: Well, I look forward to that. And I will -- I will go a step further, I'm going to follow it up and I'll send you a letter inviting you, requesting and inviting you to come to the district.

COMMISSIONER ZUCKER: We welcome that

letter. We'd like to look at the situation and we'd like to sit down with your team and -- to look at the whole scope of the problem.

SENATOR SANDERS: Then I've done everything I need to do here, Madam Chair.

CHAIRWOMAN YOUNG: Thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

Assemblyman John McDonald.

ASSEMBLYMAN MCDONALD: Thank you, Madam Chair.

And good morning, Dr. Zucker and Mr. Helgerson.

You know, a lot to like, a lot to question in a budget of this size. I do want to just mention the First 1,000 Days on Medicaid I think is a great program, really provides some additional supports and measurements, which is important.

And of course the Capital Region delegation is excited about the new Wadsworth. And then not only when, as Member Cahill was saying, but some of us are very interested, of course, of where as well.

So that being said, I want to just focus my remarks primarily on the opioid tax. As you know, I buy opioids legally, just to be clear.

(Laughter.)

ASSEMBLYMAN McDONALD: Who is the -- I guess the question is, who is really going to be the intended payer of the tax? Because when I read the language -- and I've talked to DOH, I talked to DFS. I'm not really clear who is supposed to be paying that tax.

COMMISSIONER ZUCKER: The pharmaceutical companies would be paying that tax.

ASSEMBLYMAN MCDONALD: Because when you read the language of the bill, depending on how people buy their opioids legally, it could be a couple of different people. I think the pharmacy community, the chains, the independents, have expressed their concern they they're going to be paying the tax, which technically means the consumer or the health plan's going to be paying that tax. I was told it was supposed to be the

pharmaceutical manufacturers. I can tell you who I buy opioids -- I buy them from a wholesaler in Connecticut. So technically, I might be paying the tax, the pharmacy buying from the wholesaler out of state.

So I think it's a little bit unclear and I think, you know, it needs it to be clarified one way or the other who is going to be paying the tax.

COMMISSIONER ZUCKER: So the way we put this forward is to make sure it's at the highest level, that this would not be -- that the tax would be at the companies, it would not be passed down to the consumer. As I hear what you're saying, it's -- they are the ones who have been involved in, as mentioned before, contributing to this situation, and they need to be held accountable to it.

ASSEMBLYMAN McDONALD: The question I had had brought to me was in regards to buprenorphine, which as you know is a part of Suboxone. Is buprenorphine going to be taxed? Because it can be used for -- some people have questions whether it's intended

for buprenorphine to be included.

COMMISSIONER ZUCKER: I didn't catch that, sorry.

ASSEMBLYMAN McDONALD: Buprenorphine, a component of Suboxone, is that going to be taxed?

COMMISSIONER ZUCKER: I have to check on that. I'm not sure if that would be taxed.

ASSEMBLYMAN McDONALD: That would be something we should have clarified. Because as you know, Suboxone is playing a leading role in treatment, and we want to be mindful of that.

I know when the opioid tax came out, a lot of our partners in treatment and recovery were excited, saying, you know, it's about time, we need to generate revenue for greater treatment and recovery supports. And Year One, I think $127 million is expected to be collected. How much of that is going to go towards treatment and recovery?

COMMISSIONER ZUCKER: I'll check on what percentage that will be.

ASSEMBLYMAN McDONALD: Okay. All right. And the other question I had is -- because as you know we have that very tight relationship with the federal government, some days not so tight. But is this tax going to be -- are we going to be penalized by the federal government if we add this tax? Because we're really going into a very specific class of drugs and adding a tax. Do we run any risk of decreased cost sharing or reimbursement from the federal government?

COMMISSIONER ZUCKER: No.

ASSEMBLYMAN McDONALD: Okay. I'll mention briefly -- I know Member Gottfried jumped in the MLTC. I just want to express just a thought. One of the concerns I have with this one-time or one-time annual enrollment in an MLTC program, I'm a little bit concerned about that because not every plan works out for individuals. I don't think they should be jumping month to month. But I would hope that we go back and review that, because I see many patients who are auto-enrolled in the program, had no idea,

and are not happy. And I think we need to be mindful of that in the whole process.

And the other thing I want to mention, and this is really from an upstater and a former mayor's perspective. I don't disagree with the idea of the lead inspections as part of the residential occupancy permit program. I know obviously the colleagues in New York have expressed a lot of concerns.

Is the problem as prevalent, for example, in Albany County, in regards to lead going undetected in some of these residences?

COMMISSIONER ZUCKER: Are you asking -- I'm still unclear. You're asking whether the problem with the lead --

ASSEMBLYMAN McDONALD: Do we have a high percentage of households with lead in Albany County or Rensselaer County that is requiring this to be an upstate initiative as well? The inspections by local governments.

COMMISSIONER ZUCKER: Right. So we work with the local governments on this, to inspect. And all the communities, both -- any time there's any child who's got an

elevated lead level, we will go in there.

ASSEMBLYMAN McDONALD: It's always been done at the county health department. I'm just wondering why it's extending into the actual cities, towns and villages with their code departments. That's the only reason why I'm asking in this particular instance.

You know, I used to have a code department when I was mayor, and it's hard to find good people to be able to deal with all the inspection categories. Is this really going to be successful, is my question.

COMMISSIONER ZUCKER: I'll get back to you. I'm not sure what the --

ASSEMBLYMAN McDONALD: Yeah. Okay, that's it. Thank you.

CHAIRWOMAN YOUNG: Thank you.

Our next speaker is Senator James Seward, who is chair of the Senate Standing Committee on Insurance. And if you could put 10 minutes on the clock. I don't know if he'll need it, but as chair, that's what he would get.

SENATOR SEWARD: Thank you, Senator Young.

Commissioner Zucker and Director Helgerson, I just -- I had a few questions regarding ambulance service and the Medicaid reimbursement for ambulance services.

I'm sure you would agree with me when I say that we've come a long way in terms of what care is actually provided a patient while they're in the ambulance. It's more than just transportation, there is significant care that is rendered in the ambulance. And I think the ambulance services have really emerged as a very, very important part of this continuum of care of a patient.

And I know a year ago when we were here, we were asking you where is the DOH report in terms of Medicaid reimbursement for ambulance service providers. I note that the proposed budget eliminates the supplemental Medicaid payments to ambulance providers. And at the same time, we did ultimately last year get the DOH report, and it very clearly

stated that Medicaid rates are inadequate in terms of ambulance providers.

Why does the budget propose the elimination of the supplemental Medicaid rates for ambulance providers at the same time when we acknowledge -- everyone acknowledges that the current reimbursements are well below actual costs. I've heard estimates of a hundred dollars per Medicaid patient per ride.

DIRECTOR HELGERSON: So thank you for that question.

So the budget really does two things relative to ambulance reimbursement. It does eliminate those supplemental payments. The reason for it is that we feel at the end of the day that they're not equitably distributed. But those funds are then, in the second effort, actually reinvested back into ambulance services, and in fact more than just the savings associated with eliminating those specific payments, but we actually implement two years' worth of the five-year projected phase-in of higher

reimbursements overall to ambulances.

So the report that you reference suggested a need to increase reimbursement rates to ambulances and eventually phase those in over a five-year period. We're proposing in this budget to implement two years' worth of those rate increases. And at the end of the day, this -- the supplemental payments really -- the way they're currently distributed is not equitable. And so it's -- that was the rationale for it.

But overall, this budget increases reimbursement to ambulances.

SENATOR SEWARD: As a follow-up question, do we have a firm commitment from you in terms of the full implementation? You talk about five years, but there's only two years in this budget. How can we be comfortable that we will see a full five-year implementation of these adjusted rates?

DIRECTOR HELGERSON: That is our plan, to fully implement the proposal that was developed. And that's what we're going in under the assumption that we're going to do.

SENATOR SEWARD: Mm-hmm. I think some of us may need more than just an assumption. And we can deal with that in terms of budget language, but I think it's critically important that we do have that type of -- have it on paper that that is where we're heading in terms of full implementation of the appropriate adjustments in the Medicaid rates.

A couple of other follow-ups here on this very issue. I know there's a number of other moving parts when it comes to Medicaid transportation that's in the budget, and there are some projected savings based on those moving parts, based on what the proposed budget indicates at this point.

Is the increase in ambulance provider rates, is that contingent on the other savings in Medicaid transportation that are outlined in the Governor's budget, or is this an issue that we can deal with independent of some of these other transportation issues?

DIRECTOR HELGERSON: They're actually all wrapped into and part of the overall

budget proposal. So the Governor's budget assumes a and proposes a global cap-neutral budget proposal, with many proposals within it. So this is one of those proposals, the increased reimbursement rate.

We presented it as part of an omnibus transportation package, but you can certainly separate those out. But obviously we'll see how the budget negotiations go in terms of the global cap and its amount. Based on past experience, if the three parties agree that the global cap becomes the target for Medicaid overall, then I think our challenge will be to find a way to, you know, basically lead to a final budget that's adopted that fulfills that requirement.

But, you know, you can certainly separate those proposals out and look at them independently.

SENATOR SEWARD: Yeah, I would look to deal with this issue independent of whatever may happen on some of these other aspects of the issue. That's how important I think actually ambulance service is, you know, to

the -- as I mentioned earlier, the overall continuum of care, patients that require ambulance transportation.

My final question relates to the methodology of setting the rates for the ambulance providers. I know, you know, Medicare, for example, has done an exhaustive study in terms of ambulance costs, and there is a Medicare rate. I mean, why doesn't the New York State Medicare office subscribe to the same reimbursement rate as Medicare, who have done an exhaustive study there?

And also, when the department is determining the rates in terms of your study -- I mean, did you meet face-to-face or will you meet face-to-face with ambulance providers to learn firsthand in terms of what confronts them in terms of carrying out their duties? Did you review the Medicare cost studies? They're quite exhaustive, I understand. And did you reach out to ambulance organizations as part of this whole rate-setting process?

Because we have a very diverse state.

Obviously, there are high costs in the city. We also upstate, in an area that I represent, we have -- you know, the sparsity and the distances and so on present other challenges.

So I'm hoping that you will be able to tell us that you have factored all of this in in terms of setting an appropriate rate for ambulance providers.

DIRECTOR HELGERSON: Sure. The study that came out of the past budget negotiation that directed the department to launch this study, we engaged the ambulance industry of New York State in that study. In fact, we did a survey. And in fact, one of the reasons why our report was slow to get to you was because the ambulance providers were unwilling initially to submit the information we needed in order to do some of the cost-based analysis because they were worried about the proprietary nature of the information we were requesting.

I think we were able to eventually figure out a method for them to submit that information to us. And so -- because most of

the ambulance operators are for-profit entities, so I think that's what their concern was. But we eventually were able to overcome that hurdle, and so we feel that the information that we received from them was very comprehensive.

As to the issue you raise about the Medicare rates of reimbursement, if the New York State Medicaid program paid all of its providers rates equivalent to Medicare, we would pretty much bankrupt the state. No state Medicaid program in the country reimburses providers at the same rates of reimbursement that Medicare does, Medicare's reimbursement fee schedules. And there's only a few exceptions to that rule, where we are paying the equivalent. Some of our managed care organizations pay a primary care providers equivalent to Medicare. Our hospitals do not receive Medicare-level reimbursement. And that's the case in any of the states you would find.

So I think that while you can always look to Medicare's methodology, the actual

rates of reimbursement are usually prohibitive in terms of trying to meet that standard.

But I can say definitively that we've done an exhaustive study. We've worked directly with the impacted stakeholders. And so we feel that that study and this five-year path -- actually now four-year path, if you implement two years' worth of it -- is going to lead to an appropriate reimbursement system for New York State.

SENATOR SEWARD: Well, thank you for your responses.

Thank you, Senator Young.

CHAIRWOMAN WEINSTEIN: Assemblyman Andrew Garbarino.

ASSEMBLYMAN GARBARINO: Thank you.

I want to follow up on a question that was asked about the certified registered nurse anesthetists. There's an estimated $5 million in savings, but it's my understanding that both the Medicare and Medicaid reimbursement for nurse anesthetists and anesthesiologists is the same. So where

is the $5 million in savings coming from?

DIRECTOR HELGERSON: Yes, so we anticipate actually that there would be a lower rate of reimbursement to nurse anesthetists. I can't remember how much less it is, but that's in essence what drives it.

We would adjust the managed-care rates to assume that they would have some shift away from anesthesiologists to the nurse anesthetists for the provision of those services, in obviously clinically appropriate ways, but that there is a lower rate of reimbursement for nurse anesthetist-type services assumed in the fiscal -- as I said, the actual differential I can't remember off the top of my head.

ASSEMBLYMAN GARBARINO: Currently I believe it's the same, but you're planning on the med -- the team or whoever is just going to change the reimbursement?

DIRECTOR HELGERSON: Yeah, I mean that -- off the top of my head, I know we are assuming it. I'm not sure whether or not we actually have to enact it or not or whether

or not there are general already differences in the rate structure, particularly the rate structure paid by the managed-care organizations.

ASSEMBLYMAN GARBARINO: Okay. I'm going to switch over now to the conversion of insurance companies. There's $700 million a year over the next four years, so total of $3 billion. Five hundred goes to the financial plan, I believe, and -- or is under the spend of the financial plan, and 250 goes into this shortfall fund. What happens -- or are there any companies that are currently converting from non-for-profit to for-profit insurance companies?

COMMISSIONER ZUCKER: I'm not sure exactly whether there are or not.

ASSEMBLYMAN GARBARINO: So I don't understand, where's the -- I don't understand, where's -- where's this estimate of money coming in, coming from?

DIRECTOR HELGERSON: So right now the department is currently reviewing a sale of one not-for-profit health plan to a

for-profit entity. That would be potentially impacted by this proposal. So yes, there is one.

ASSEMBLYMAN GARBARINO: So -- but what happens if -- I think you're talking, you know, about Centene's buying Fidelis.

COMMISSIONER ZUCKER: Fidelis Institute, yes.

ASSEMBLYMAN GARBARINO: What happens if now because of this new -- you know, they're expecting to take $750 million in revenue from just this one conversion every year for the next four years. What happens now if the deal falls through because of this?

COMMISSIONER ZUCKER: Well, we're looking at that right now. That's in the process of negotiations. So we'll be able to talk a little bit more about this once we see what happens in that. And I don't want to go into the details of the process because it's, you know, under review.

ASSEMBLYMAN GARBARINO: Okay. So let's just say it doesn't go through -- I

know, we don't have to talk about it. The $500 million for the General Fund, is that -- how are we going to make that up if this doesn't --

DIRECTOR HELGERSON: I think that's really a question for Robert Mujica, because it's a financial plan impact --

(Laughter.)

DIRECTOR HELGERSON: -- not a Medicaid global spending cap impact.

ASSEMBLYMAN GARBARINO: Okay. And this shortfall fund, I just believe it's being funded by this and the 14 percent tax. It's based on, I guess, whether or not the federal government doesn't pay us as much as we want or we need. So is this money only going to be used if there is a shortfall from payments from the federal government? Or is it just we get to use it no matter what, even if there's no shortfall?

COMMISSIONER ZUCKER: Well, right now we believe the 14 percent -- you're talking about the 14 percent, right?

DIRECTOR HELGERSON: He said the fund.

ASSEMBLYMAN GARBARINO: The 14 percent and the $250 million from the conversion. What will it be used for?

DIRECTOR HELGERSON: I mean, I think the Governor's intent is that those monies are available in case there's a shortfall. Now, those monies would be potentially available, you know, for use for other purposes other than -- you know, assuming the budget is proposed.

But I think the Governor's view on that was that it made sense to earmark some funds, given all the uncertainty in Washington. I think it's the fiscally responsible thing to do, and monitor it.

But obviously if funds are appropriated for that purpose and they're sitting there and if at some point we have crystal clarity in terms of what Washington's intentions are and we have a hundred percent confidence that there are no risks at that point, then potentially those funds could be appropriated for another purpose.

ASSEMBLYMAN GARBARINO: All right, so

there's no -- right now we're doing it in anticipation of a shortfall, but there's no limitation that it be spent if there isn't -- I mean, that it's given back or -- if there is no shortfall.

DIRECTOR HELGERSON: Yeah, I think that's really at the discretion of the budget director, is how I think it's structured.

ASSEMBLYMAN GARBARINO: Okay. Thank you very much.

CHAIRWOMAN YOUNG: Thank you.

Senator Ritchie.

SENATOR RITCHIE: Good morning.

COMMISSIONER ZUCKER: Good morning.

SENATOR RITCHIE: I represent a predominantly rural area in the North Country and Central New York. My questions center around the fact that we are now approaching what seems to be a critical level with regard to a shortage of healthcare professionals. So I'm wondering whether the department has a plan in place or resources in the budget to actually address the level of shortage when it comes to nursing and doctors in the area.

COMMISSIONER ZUCKER: So I think this goes to the issue of workforce. And we are looking at this from different fronts. One is we're looking at it from our -- the SHIP program, and we have a workforce subgroup to look at how do we get health professionals up into the rural areas. There are many different factors involved in that, and that's what they're working on. That's one part.

Another part is the issue of who else can provide some of these services. We do have a discussion, as you probably see in the budget, about EMTs and paramedicine, others working within their scope of practice. So could an EMT, and we believe so, an EMT provide some of the service besides bringing someone from a home to a hospital and to do some of those services that could be provided in that area.

We are also looking at the issues of telemedicine, can someone -- as Senator Young has been very interested in -- can we get some of those services that would normally be

done in a hospital or actually sent to or taken to a hospital, particularly in a rural area, provided through telemedicine. So it's another area.

Can we ask pharmacists to work within their scope of practice and to provide some of the services -- the Governor for this past flu season issued an executive order about having pharmacists be able to give immunizations to 2-to-18-year-olds. And so we are looking at what other things we could do to make sure that someone doesn't have to run a distance to get care. We are also looking at what other things that nurse practitioners can provide.

And then it goes back to the issue of how do you get more health workers into the rural areas of the state. I recognize this is a challenge. And having traveled around the state, I recognize that sometimes people have to go a long distance for care, and it's a challenge not just for the patient but also for those who are caregivers and particularly those who will have to take a day off from

work to do that.

DIRECTOR HELGERSON: Can I add one more thing too, just on the Performing Provider Systems in DSRIP have already spent $241 million on investing in workforce issues. They were all developed to develop comprehensive workforce plans.

Understanding full well exactly what you're saying, I think some of the North Country, in particular, PPSs have some great success stories of where they've made targeted interventions, where they've, say, hired a dentist into a county that hadn't had any dentists for four or five years. But there's a -- we certainly provide you with the information. There's still more money to be invested by those organizations. So that's another potential funding source for the kind of investments that we agree with you are 100 percent necessary in order to ensure that all New Yorkers have access to the services they need.

SENATOR RITCHIE: So recently we've been working with one of the local colleges

who actually has a nursing program, and one of the obstacles is actually getting instructors. So I'm just wondering if DOH could work with SUNY in order to see if we could address the issue about getting instructors to local colleges to help with the nursing program.

COMMISSIONER ZUCKER: Sure, that's something we can definitely do, and we'll work with the universities on that.

SENATOR RITCHIE: And one of the other questions is a follow-up on the nursing home question. I was actually a little surprised at your response that in other locations nursing homes that are closing, someone else is looking to move into that spot. That's not what's happening in my area. On a regular basis I'm having conversations with those who either have recently closed a nursing home program down or are teetering on the edge of potentially doing that.

So in rural areas, again, do you have any plans on how to address the nursing home crisis?

DIRECTOR HELGERSON: Sure. So in terms of nursing homes -- well, first off, in terms of nursing homes there are a number of programs that have been created over recent years designed to support particularly financially fragile nursing homes. So we've got Vital Access Provider as a program, for instance, that's helped some of the rural nursing homes survive and hopefully convert into models that are going to ensure long-term sustainability or eventually potentially merge into a larger chain, which may support them in continuing operation in that community.

The one other element to the budget that is included is a major expansion of ALP, so Assisted Living Programs. That's another exciting opportunity, investment both of operational funds as well as capital, I think it's $30 million of capital funds being allocated to expand ALP.

Specifically of those ALP beds, there's a specific focus on the counties, particularly rural counties that do not have

ALP services today. So that's another potential. Because at the end of the day what we want are people who have long-term-care needs to have a variety of different options for them. And I think that individuals who -- don't always have to go to the nursing home. There are opportunities outside of the nursing home. You know, whether that's home care services or assisted living, that we want to try to grow.

SENATOR RITCHIE: I know you've discussed telemedicine, and it's something that has been very helpful in my district. But this year proposed again is a 20 percent cut to the Rural Health Network Development grants, and it's something that the Fort Drum Regional Health Organization utilizes in order to integrate the community healthcare system with Fort Drum, along with a big part of it being telemedicine.

So we're just wondering, because of the cut that's proposed, how do you propose these organizations address that cut?

COMMISSIONER ZUCKER: Well, again,

we're looking to try to figure out a way that some of the other programs that we have within the department could be able to provide some of the services that are -- that some feel are being cut.

I don't think that -- I don't think that in the long run that patients will be -- there will be a compromise to the patients, because we are looking at making sure that other parts of the department will cover any of the cuts in some of these areas.

This is -- as I said in the testimony, this is a tough budget season, but we -- our primary focus is the people of New York, whether it's upstate or downstate. And what I mentioned before a little bit about what we can do in the rural community, we are pushing forward on.

And there are many other aspects of the department, some of the other programs that we're doing, that also tie into this. And although it's not directly related, it's indirectly related. We have the SHIN-NY, which is our information network, and a lot

of information is provided. And so if somebody ends up in a rural area and they have to go to a hospital closer to them, but they usually go to a facility or a hospital further away, the ability for this to interact and to connect will provide the services that they need, or at least the information to the doctor or the nurse who's there so that the services they need can be given to them. And that will help.

SENATOR RITCHIE: And just in closing, we have some real issues in my area with regards to access, because it's so rural. So I would just like to reinforce Senator Valesky's comment on the safety net program. I know your department has provided resources that has helped the hospitals over the last year and a half, but some of them are still teetering on the edge. And when you're a community in the middle of the Snow Belt and that's the only hospital you have, even though you may not be financially in a great place, it's still important to make sure that the healthcare system is still open to those

who live there.

COMMISSIONER ZUCKER: We absolutely recognize that. And having had the opportunity, as I said, to go to some of the hospitals and recognize that the services -- those are the services for that community. And we have, as I mentioned before, capital grants to support improving the facilities that are there. So I hear you, I completely hear you.

SENATOR RITCHIE: Thank you.

CHAIRWOMAN WEINSTEIN: Before we move on to the next speaker, we were joined actually a while ago by Assemblyman Felix Ortiz and Assemblyman Tom Abinanti.

And now to Assemblywoman Solages.

ASSEMBLYWOMAN SOLAGES: Good afternoon. First I just want to circle back with the statewide Medicaid transportation systems. I really think that's the wrong way to go. If you look at the local model that we have in Nassau County, Senior Ride, they have trained, certified professionals who pick up the patients. Every day they're the

same person that picks up the same patient. They have video cameras on their cars. This MAS doesn't have video cameras. They don't have trained professionals. You know, it's a different driver for every pickup.

And so, you know, I think if we have a good product, we should be supporting that model. And I think that going to a statewide system is something I don't agree with. I think it's going to cause more headaches than it's going to help.

So I want to go to speak about actually our littlest New Yorkers. And I want to talk about the First 1,000 Days initiative that New York State is now doing. It's very exciting that we're focusing on providing safe, stable and supportive initiatives for our toddlers and our infants and for our mothers too.

And so I just want to first ask the question, how are we integrating home visiting services with that model?

DIRECTOR HELGERSON: Sure. So thank you very much. We are very proud of the

First 1,000 Days. I note that it was cochaired by Nancy Zimpher, the former SUNY chancellor, who was still SUNY chancellor when she took on the role, and MaryEllen Elia, who's obviously the commissioner of the State Education Department. So led by people from outside of healthcare to demonstrate this was really meant to be a cross-sector collaboration.

So there are 10 proposals, one of which is to expand access to home visiting. And obviously there's budgetary constraints, but there are funds available, both this year and proposed for the next year, to begin to grow that program out statewide, because we think it is one of the most cost-effective ways to improve things like school-readiness. If we can work with high-risk expectant moms and then right after children are born and those families, we think it's a very cost-effective strategy and we want to grow it over time.

ASSEMBLYWOMAN SOLAGES: One thing, though, last December I saw there were

10 points, and there was a major missing component, and that was breast-feeding. It didn't really discuss promoting breast-feeding or promoting exclusively breast-feeding for the first six months. It talked nothing about making sure that mothers were provided with donor breast milk if they couldn't breast-feed. And so can you elaborate on why that point was missing?

DIRECTOR HELGERSON: So lots of proposals were brought forward, and we sort of forced prioritization to try to focus in on 10, mostly because what we wanted to do is to try to have this diverse group of people, the diverse set of stakeholders coalesce around at least an initial set of 10 things that we would work on. In no way, shape or form was that meant to say there aren't other things that we should prioritize and work on. But this was the initial 10.

So I can't remember off the top of my head where that proposal was, but it doesn't mean that as we move forward, as we get beyond these 10, that we can't and shouldn't,

you know, look at other ideas, including what you mentioned is a really important priority, which is to promote, you know, in terms of breast milk and making sure that that's promoted in every way, shape or form.

ASSEMBLYWOMAN SOLAGES: We know breast milk is a superfood, so we want to promote mothers to breast-feed.

So what were your departments doing to promote breast-feeding among first-time mothers or in general to parents?

COMMISSIONER ZUCKER: I couldn't hear what you asked.

ASSEMBLYWOMAN SOLAGES: So what are your departments doing to promote breast-feeding, especially for first-time mothers?

COMMISSIONER ZUCKER: Sure. We have a very active program, working with the community, working with local health departments, getting the message out this is one of the commitments of our prevention -- part of our prevention program. We are moving forward with getting hospitals to be

focused primarily on breast-feeding. This is done across the state as well.

And I think that the message is clear -- obviously the benefits, but I think the message is clear of the commitment on the part of the department.

ASSEMBLYWOMAN SOLAGES: Okay. And I know that there was a proposal in the Executive Budget regarding maternal mortality. Could you elaborate more on that?

COMMISSIONER ZUCKER: So the Governor is committed to the issue of addressing this issue of maternal mortality. We have actually a meeting about this in two days from now in the city.

And this is part of his bigger agenda regarding women's health and, as you know, his commitment to women's health from several years ago, even with breast cancer and some of the great strides we've made in that area. And we are moving forward to address the fact that New York is not as high as we want us to be in having the lowest amount of -- or no maternal mortality, I should really say.

So we're going to find that, we're going to figure out what the problems are, we're going to address it, we're going to tackle it, and we're going to solve it. And New York will address whatever problems -- not only just maternal mortality, but also maternal morbidity. We will look at those issues as well. We are going to track the numbers and try to figure out how to solve them.

ASSEMBLYWOMAN SOLAGES: Because, you know, every day we're losing mothers. And, you know, a study is great, but we need to move on proposals like making every hospital in New York State a baby-friendly hospital and pushing forth an initiative such as that.

COMMISSIONER ZUCKER: Right. We're moving on that.

SENATOR KRUEGER: Thank you.

Senator Diane Savino.

SENATOR SAVINO: Thank you, Senator Krueger.

Good afternoon, Commissioner. Good to see you, as always.

I'm not going do ask you the same questions as everyone else has asked, but I would like to just get on the record that I also have serious concerns about the changes to managed long-term care and the direction that we seem to be going. It's a program that seems to have been working for a lot of people, and I have questions about it. You don't have to respond now; I just want to make sure you understand I also share the concerns that have been raised.

I also share the concerns that have been raised about the global cap and the effect it's having on our healthcare delivery system. As you know, on Staten Island we only have two hospitals and we always say one of them is on life support. And so this cap on Medicaid reimbursements that's been in place for more than eight years now is having a direct effect on the service delivery and on the workforce as well.

I want to turn, though, to something that you and I have worked on for several years now -- it seems like yesterday -- but

the medical marijuana program.

First I want to thank you for the changes that you have helped shepherd through. The program, as you know, is now up to 43,000 patients and 10 licenses, and hopefully we'll get more dispensaries across the state. But one of the things that as the state grapples with the opioid abuse crisis, Assemblyman O'Donnell and myself have introduced legislation to add addiction disorder as a qualifying condition under the medical marijuana program. Because as you know, many people who are in recovery for addiction, opioid addiction, are using medical therapy -- Suboxone, Vivitrol, and methadone.

So we're proposing to add medical marijuana as one more of those proposals. You don't have to answer now, but I would like you to take a look at that and consider it. I believe we need all the tools we can possibly have in our toolbox to help grapple with this crisis.

The other issue marijuana-related in

the budget, the Governor has proposed a study to examine I guess the safety -- I'm assuming it's the safety of an adult-use marijuana program, because I can't understand why it's under your purview. So maybe you can talk a bit about this commission that he's --

COMMISSIONER ZUCKER: Sure. So the Governor has asked in the budget proposal to have us do a study looking at regulated marijuana.

The issue is not just health, it's issues of transportation, because there are neighboring states, it's justice issues -- there are many different factors. But the ask is that we do a review of this, look at what other states are doing, try to gather the facts and to make a decision on a -- on this decision about a regulated marijuana program.

So we will do that. We will pull it together, and we will get all the information we need and do this very thoroughly and provide the Governor with what we've found.

SENATOR SAVINO: I'm glad to hear

that. Because, you know, I've shared with the Governor that this is an issue that's going to be of concern to our medical program. We're going to have marijuana to the left of us, to the right of us, to the north of us, to the south of us.

And remember, in our legislation a patient in New York State, if they go outside of the legal regulated market, are committing a felony under Public Health Law as well as under the penal code. So it's even more important that we study this as quickly as possible, because as you know, the cost of the medication in New York State is particularly high for patients. And if they can get access to a legal regulated product in another state, they may be more likely to do that. But they jeopardize their freedom.

So I just want to leave it at that. It's very important.

And with the limited time I have left, I want to turn to an issue that is not related to marijuana for a change. Last year, the Governor's office required a cost

study be done in 2017 about the ambulance reimbursement rates. So the study -- from what I understand, the study showed that the base rate for non-emergency transport is $250, yet the state is only reimbursing them at $155. So if you all determined that the cost is 250, why are we only reimbursing them, you know, almost 50 percent less of what it costs to transport patients?

I know others have addressed the issue of patient transportation, but I'm just baffled as to how, if we've determined this is the cost, why are we only paying them just about half of what it costs?

DIRECTOR HELGERSON: So I think the point of it was that we propose basically to phase in, over a period of five years, a new rate structure that more closely aligns Medicaid reimbursement with cost.

But I would say that, generally speaking, Medicaid in other sectors doesn't always fully reimburse costs, at least as some define it, in the healthcare sector. I think we could probably point to other areas

of concern in terms of overall rates of reimbursement.

But I think that what we're proposing is a good step in the right direction, this two-year phase-in, the first two years of a five year phase-in. But that's what this study suggested was the right way forward. We worked with stakeholders to complete the study. And so we think that within about four years we'll have raised reimbursement rates to those higher standards.

SENATOR SAVINO: Just one final point on that, though. Over the same period of time, the State of New York is going to be imposing a higher minimum wage on every one of these employers. Many of these transport staff are paid a little bit more than the minimum wage, some of them just the minimum wage. So their costs are going to continue to go up, the cost of fuel is going to go up, the cost of insurance is going to go up, the cost of just maintaining these vehicles will go up, but we're going to be depressing their wages across the board.

I think there's something wrong with that math. I'm not a budget genius, but even I can figure out it's going to be very difficult to find people to transport patients if we continue to cut their reimbursement rate and then at the same time saddling them with higher costs.

DIRECTOR HELGERSON: Sure. I would only say is on the minimum wage piece, there actually is a separate pool of funding to provide providers with higher reimbursement tied specifically to the implementation of minimum wage. So that particular issue is addressed elsewhere.

SENATOR SAVINO: Thank you. My time is up.

CHAIRWOMAN WEINSTEIN: Thank you.

Assemblyman Raia -- Ray -- Ra. It's been a long day.

(Laughter.)

ASSEMBLYMAN RA: Cousins from the old country.

ASSEMBLYMAN RAIA: That's right.

(Laughter.)

ASSEMBLYMAN RA: Good afternoon.

I just wanted to go back to the opioid surcharge about just -- I mean, we know as we've looked through this that a number of states have talked about or tried to enact something like this, and obviously it's a complex situation and there are so many different ways through the distribution chain.

What would happen in the situation of a patient receiving mail-order drugs? Where -- at what point in the process would that surcharge be paid?

COMMISSIONER ZUCKER: So again, it would go back to the company, the charge would go back to the company. We will work out the details of exactly how this will move forward.

I know everyone's, you know, concerned about the charge, but I think that we need to look at the bigger picture here also about how many people have died as a result of this opioid epidemic. And in New York State, the stories are really quite worrisome. We've

had 3,000 deaths in 2016 and 2017. I'm sure, unfortunately, there may be more. And we need to tackle it. And I do think that the charge for this will -- the monies generated from that charge will go to the efforts to take on this problem.

DIRECTOR HELGERSON: And if I could just add, too, the good news is the Department of Health is not responsible for administering the tax --

(Laughter.)

DIRECTOR HELGERSON: -- so I think any questions regarding how the tax would be administered are probably best directed to the Department of Tax & Finance.

ASSEMBLYMAN RA: Which is why I won't ask you to comment on that -- I agree with you 100 percent, this is obviously a major problem, something all of us are experiencing in our districts. And perhaps a lot more of a percentage of this proposed surcharge should be going into actually addressing the problem, where a lot of us know that a very small amount of it is proposed to do so. But

I'm not going to ask you to comment on that.

I wanted to move on to just a different issue that we've dealt with a few times in the past, and I know it was in the budget last year -- I think last year it was called limited service, this year we're calling it retail practice, these clinics -- and in particular one of the concerns that, you know, we've always heard, but particularly at a time when we know there's a major pharmacy chain that has pushed for this that's already in the PBM space and is talking about a merger or an acquisition of a healthcare insurer.

So my concern is, you know, what is the benefit that we see from -- you know, these types of entities are definitely part of the future of medicine delivery. There's these clinics for immediate care in many of our communities, but currently they're subject to being owned by some type of doctor. What is the proposed or purported benefit of allowing corporate ownership of these clinics?

COMMISSIONER ZUCKER: So these retail practices -- I think we -- again, looking at the big picture here on this, is there's a lot of healthcare transformations, we know. How care is being provided is way different today than it was five years ago, 10 years ago, and surely 20 years ago. And I'm looking at this wearing two different hats. One is the hat of being in this role, and one is the hat of somebody who provided care to patients.

From the hat -- this hat, as working in government, we need to figure out how to get access to care to more individuals and necessary care or emergency care that may be available. If we have retail practices that could provide some of this care, particularly some emergency, look at something, check someone's blood pressure, check their glucose, let's say a diabetic or something, then that will be in the best interests of the whole healthcare system, rather than having someone run to an emergency room.

Looking at it from the standpoint of a

clinician, many doctors have told me that their office is filled with patients and they don't have enough time actually to see those patients because their waiting room is just filled and they're ending up spending five, 10, 15 minutes, get them in, get them out. That is not in the best interests of good patient care.

If you could provide with these retail practices a way for some of this care to be offset from the doctor's office, there will be additional time available for that health professional to be able to sit down and have the longer conversation, discuss other things with the patient, and not feel that they're rushed in and rushed out.

So this is all the bigger picture of the transformation of care. So part of it is the emergency room, taking patients away from just running to an emergency room, and part of it is also making people's practices a little bit easier for them to provide more care to patients.

ASSEMBLYMAN RA: Thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

SENATOR KRUEGER: Thank you.

Hi, it's actually my turn. And I have so many questions and such a short amount of time. So I might actually sort of run through the questions and you see how much time you have to answer --

DIRECTOR HELGERSON: (Laughing.)

SENATOR KRUEGER: No, I'm serious.

-- and then take notes and know I want to hear back from you on the things you didn't think you could answer.

COMMISSIONER ZUCKER: Okay.

SENATOR KRUEGER: Okay, so we talked about CHIP before and the fact that we did get the federal money to keep it going, thank God. So a question: Why does the budget still have language that would allow you to change rates or freeze enrollment or make other programmatic changes, since it doesn't appear that you need that language anymore?

That's a note.

Next, we talked about concerns -- excuse me, too many pieces of paper -- also

about the Essential Plan and the fact -- and some things that are in the budget but maybe we don't need because maybe the feds won't do it, but it does appear that the administration in Washington has cut the cost-sharing reduction money and that that's a significant amount of the funding we spend for the Essential Health Plan, which impacts, I think, 700,000 people in New York State.

So I'm very concerned about how we make sure that we are continuing the Essential Health Plan and would also like to know are you planning, again, reducing the payments, reducing eligibility, changing something else about the program, since it does appear -- my notes show that we lose up to a billion dollars from the federal government for that program, so I'm curious how we're going to fill in the gaps.

A number of people talked about the concerns for primary care, and you talked about rural care shortages. If we're so focused on expanding primary care and pediatric care, why are we reducing Medicaid

funding for these programs, particularly for pediatricians and other patient-centered primary care programs? It doesn't seem like it's the time to reduce Medicaid formula payments for exactly the kind of healthcare we're talking about having a very real need and goal to expand.

See, he takes notes very fast. Nice seeing that. Thank you.

SENATOR HANNON: There's no ink.

SENATOR KRUEGER: No ink? Stop that. Yes, there's ink. There's ink, right? Tell me there's ink.

DIRECTOR HELGERSON: Yes, there is. I promise.

SENATOR KRUEGER: Thank you.

We had a series of questions around the Governor's First 1,000 Days of Life program. And I'm a big supporter of expanding these programs. But I'm very disturbed that when you look in the budget, he's actually cutting 20 percent of the funds out of maternal and child healthcare programs, even though there's all this new

commitment.

And specifically, he talked a bit about the importance of expanding healthcare for maternal depression, an issue that I have worked on for quite a few years now. So I'm curious how the Governor is going to implement his expanded programs for maternal depression, matching providers with mental health specialists once a woman has been diagnosed, when we're actually cutting the funds that are available -- you know, in the pot of money that you cover maternal depression and maternal mortality, you're cutting the funds. And it seems to me to be pretty counterproductive.

Then -- oh, good, I'm just running along. So there's a real concern that's been raised, there's a lot of issues in MLTC rates that were raised. But one that I don't think I heard yet was the concern that for the most acute patients, there's already been a serious question about rate adequacy and that you're going to be changing the scoring in some way that makes it even harder for people

to be found eligible for care on the acuity score, is the term, that I was told that there would be an increase in acuity score required to get access to home care services.

So if we're already hearing that people who have the most severe need are actually not always able to get the care they need, wouldn't increasing the acuity score be an added problem as opposed to some kind of solution for us at this time?

And in my 43 seconds that's left, I raised with Dr. Zucker the other day, so I'm just raising it again so he can follow up with me, concern around the decision to go sole-source for Alzheimer's and dementia care services in the state, including continuing a contract to an out-of-state hotline which doesn't actually provide direct services to people in New York, and some people are not clear that if you're a national hotline, you even know where you might find the right place to refer people to throughout the 62 counties of New York.

And I have used my five minutes. So

you want them to get back to me later? How do you want to handle this?

CHAIRWOMAN WEINSTEIN: How about a short speed round?

DIRECTOR HELGERSON: Speed round. On CHIP, language was put in there because of the potential loss of federal funds. Certainly something to be reexplored since that threat is no longer there.

CSR in the Essential Plan. Big impact on New York State. The 25 percent of the funding that goes into a program that serves over 700,000 New Yorkers was a big thing we had to solve for in this budget. The good news is that the budget as proposed doesn't take away healthcare from anybody, doesn't increase anyone's cost sharing. We're able to basically find sufficient savings overall in the program so that there is -- there's no impact on New Yorkers because of the Trump administration's decision to end CSRs.

That said, the Attorney General is launching, as has -- along with the State of Minnesota, launched litigation on that

particular issue.

PCMH funding cap, it's a budgetary initiative, very fast-growing program. Significant funding went into those primary care practices to achieve a PCMH level from the DSRIP program, so we felt that it was a cap that was reasonable and appropriate, but understand the concern about it. But still we're going to spend north of $100 million in supplemental payments to practices that meet those national standards.

The last one I have before I turn it over to Dr. Zucker is MLTC, the change in the eligibility from 5 to 9. Actually the reasoning for that is to focus the program on individuals who have the most needs. It's a very high touch, very expensive care management program. And so the idea is that the individuals with acuity scores below 9 will be able to access services in fee-for-service. We already have many people that receive short-term home and community-based services through fee-for-service, so it just slightly increases the

number of people that would be getting it through that door, fee for service, as opposed to through managed long-term care.

I can't remember off the top of my head the number of individuals affected, but it's relatively small and we grandfather in anyone who currently is in the program.

COMMISSIONER ZUCKER: Regarding the Alzheimer's issue, that contract actually is with the New York State Alzheimer's Coalition, which is based in New York. It's actually headquartered here in Albany. So the contract won't leave New York State, it stays within the state on that issue.

And on the other issue regarding the 20 percent cut, this is where we look at other -- we're working with the Office of Mental Health, and Dr. Sullivan and I have looked at how can we address some of these issues. It ties more into the whole issue of advanced primary care where we look at providing primary care and behavioral health together. And I think there's a way by doing that to not end up -- that 20 percent cut

won't be impacted as much.

SENATOR KRUEGER: We don't necessarily agree on all those answers, but thank you for giving it a good shot.

CHAIRWOMAN YOUNG: Thank you.

CHAIRWOMAN WEINSTEIN: Assemblyman Kevin Byrne.

ASSEMBLYMAN BYRNE: Thank you. And thank you for your patience throughout this hearing.

I just want to follow up on some things I think Mr. Gottfried may have asked about earlier.

I know New York State has historically supported various smoking cessation programs, including tobacco quit lines and things of that nature. And I know the Legislature and the Governor -- I think, in my opinion -- has acted responsibly this past session in strengthening the Clean Indoor Air Act and protecting our children in schools with restricting e-cigarettes on school grounds through different policy measures.

That said, I want to ask about where

the funding is for those smoking cessation programs now. Specifically, I think Mr. Gottfried may have asked about -- it's a little bit different, but the New York State asthma program, as well as reduced funding.

And I know this is something that is important to the children in New York State. I believe over 400,000 children suffer with asthma in the school system right now. So if you could speak to that.

And I'm going to try to just run through this as well, for the sake of our time. And I note -- so on a completely separate topic, you've already spoken about the opioid tax surcharge several times. My specific question is that I know, from my understanding, several other states have tried to implement other sorts of programs as well on opioids, so I want to know what differentiates this from that.

And if you can't answer it and defer, I understand, but specifically, how is this going to -- you know, a lot of us are concerned on how this surcharge could go to

the consumer. I'm concerned about folks who receive palliative care specifically in hospice. I have received multiple inquiries from providers of hospice treatment, folks who are in need of palliative care. It's not something that we want to be penalizing them with added costs. So if there are any assurances you could provide to make sure that that tax burden won't be shifted onto them, I would appreciate that.

If you could speak to the smoking cessation program and the funding for that as well as hospice treatments.

COMMISSIONER ZUCKER: So we are -- regarding this tax, I understand what your concern is about hospice care and making sure that it doesn't end up being a burden placed upon them. We -- we will -- be assured that that will not be something which will be compromised. We always look at the issues of hospice care.

And this goes about back to the issue of whether it's chronic care or whether it's those who are in end-of-life care and making

sure that we provide the necessary services.

So again, the tax is -- the opioid tax is high level and making sure that this doesn't get filtered down to the end-user on that.

And regarding smoking and other -- we have an aggressive program in this state regarding smoking. We have dropped the percentage of kids who are in high school smoking basically in half, and even further. One of the concerns we do have is this issue of e-cigarettes which is now surfacing and it's bringing kids -- those numbers have risen in the last two years from five to 10 percent in high school. I'll check that number for sure, but I believe that's right. And we will continue to be very aggressive on the issue of smoking. New York State has been a leader in the nation on this, and we have been praised for that by the CDC and other agencies about how aggressive we have been on that.

ASSEMBLYMAN BYRNE: I'm sorry, can you speak to any -- is there any change in levels

of funding for this year from prior years in regards to supporting those types of programs?

First of all, I think there is credit definitely due for the work that New York State had done, but also across the country. I think I read a report just a couple of months ago that the CDC said that for the first time, there's actually been a little bit of a drop in e-cigarette use among teenagers. But I'm not sure what those numbers are in New York State, and they're still very high. Just because there was a drop does not mean that they're acceptable.

But if there's anything -- is there any changes in the level of funding to support tobacco quit lines or anything like that?

COMMISSIONER ZUCKER: Well, I can get you the numbers on the percentages for the funding on this and get back to you on the exact numbers.

But like I said before, this is one of our hallmark programs, smoking cessation, in

the state, and so we're not going to let anything happen to back pedal on that issue.

ASSEMBLYMAN BYRNE: Thank you, Mr. Commissioner.

CHAIRWOMAN YOUNG: Thank you. We've been joined by Senator Marisol Alcantara.

And our next speaker is Senator Sue Serino.

SENATOR SERINO: Thank you, Senator Young.

And I'd also like to say thank you to Assemblyman Cahill for allowing me to ask my questions on Lyme and tick-borne diseases first. Thank you.

Thank you very much, Commissioner and Director, for being here today. As you know, I chair the Senate's Task Force on Lyme and Tick-Borne Diseases.

And Senator Hannon and I were very encouraged by your participation in our recent public hearing that we held on the topic. At that time you had announced that you had a statewide action plan to address the issue, something that we can all agree

needs to remain a priority, but you made it clear that your office recognizes the seriousness of the epidemic the state is currently facing.

And while I was encouraged to hear that the Governor included some small Lyme-related initiatives in his State of the State address, I was incredibly disappointed to see that there wasn't specific funding dedicated to research, education or prevention for Lyme and tick-borne diseases in the Governor's budget proposal. Could you speak to that, please?

COMMISSIONER ZUCKER: Sure. The Governor is extremely committed to this issue of tick-borne diseases, whether it is Lyme disease or anaplasmosis, Ehrlichiosis, babesiosis and all the others that we're concerned with.

We've had a very aggressive program on this front. We are working with other departments across the state, we're working with Parks and Recreation, we're working with DEC, we're working with the community, we're

working with hunters and making sure that they're aware of the risks of ticks.

Our lab is looking at issues of public-private partnerships -- more on that in the future, but we are tackling that issue as well. And we are looking at what are some of the new novel approaches we can have for treating the issues of not just Lyme disease, but other tick-borne diseases. I've had actually meetings with the community on this, commissioner's grand rounds on these issues, and we'll move forward on this as well.

SENATOR SERINO: And I appreciate that. But there isn't a dedicated line for funding, and that's what I'm concerned with.

You know, like Senator Young said earlier, we have constituents in our district that we have to answer to. I have people that come into office that can't walk, don't have a memory, can't work anymore. And I don't know if I had spoken to you about this before, but I had a brother that was not diagnosed with Lyme disease for eight years. He committed suicide seven years ago. And

the more I learn about Lyme and tick-borne diseases, the more it makes me wonder what role that had to play.

And, you know, every year we do our budgets and we have the good and the bad, the things we like and the things that we don't like. Last year, for example, we put $200 million into lighting up bridges. How do you think the people that have Lyme and tick-borne diseases feel about that? They're going to say it's ridiculous. Or that's probably not the right word that they would choose. But how do we explain that to them?

So I'm very concerned about having funding. And I appreciate the private-public partnerships too. As you know, the first two years I was here we put $600,000 in the budget and then $400,000 last year, which is pitiful. But the year before we had the Cohen Foundation donate $5 million to the Cary Institute in order to do Lyme and tick-borne research with the Cary Institute for The Tick Project. So that was very encouraging.

COMMISSIONER ZUCKER: And I understand you're bringing up more the issue of chronic Lyme disease and those who have this for obviously years, and what we can do for them. And we will look at that as well.

SENATOR SERINO: And that brings me back to the testing. Because I hear so often that our test is not accurate. So if there's something that we could do, whether it's a public-private partnership to do more research, I think that's incredibly important as well.

And also recently, in fact it was July of 2016, a bill that I sponsored with Assemblywoman Didi Barrett was signed into law that would require the Department of Health to work with the State Education Department to develop age-appropriate materials for schools to use if they wanted to teach students about how to protect themselves against Lyme. And I know you and I have had this conversation before, because I go to the classrooms. I was just in a middle school the other day, and a third of

the class -- we don't even have a half of the class raising their hands that they know about Lyme and tick-borne disease. So it's so important that we have that material.

But I was just wondering if we could get a status on it and when the schools can expect to receive those materials.

COMMISSIONER ZUCKER: So I will get information about the timing on this, and I promise you that I'll sit down with SED and figure out how we can move forward and make sure the education component of this is met.

SENATOR SERINO: Yes. And I was very encouraged when we spoke about it that you saw the importance of that too.

I was also very encouraged to learn that you are including Lyme and tick-borne diseases in your grand rounds this spring. And you and I have already spoken about this, but I do want to encourage you once again to be inclusive in the specialties that you are including in this work. As you know, I have heard from countless advocates who were incredibly disappointed to learn that ILADS

won't be represented. And while I understand that there's a debate surrounding this issue, the fact there is a debate tells me there's no clear consensus. And until there is, these events should be inclusive, and I would appreciate your consideration on that matter.

And I'm out of time. Oh, you know what, can I just ask you two more statuses on Lyme and tick-borne disease in New York this year, particularly given the warm winter that we've been having, if you have a number. And the other question is to the status of the cases of Powassan in upstate New York and if they test positive in the later survey results.

COMMISSIONER ZUCKER: And we did have a handful of cases of Powassan, and we are tracking that. And it varies from year to year, and we recognize that this year was a more serious year.

But again, it goes back to are there other -- as you just mentioned, about other tests, faster tests. And that's where we work with our not only partners outside of

government but obviously our lab and the experts that we have there.

SENATOR SERINO: Okay. Thank you, Commissioner.

CHAIRWOMAN WEINSTEIN: Thank you.

We've been joined in the Assembly by Assemblywoman Jo Anne Simon.

And now to Assemblyman Abinanti.

ASSEMBLYMAN ABINANTI: Thank you, Madam Chair.

Thank you, gentlemen, for joining us this morning.

First of all, let me start with something I agree with you on. I think the suggestion of the opioid tax is a very good one, and I would like to see you double it. I believe that that would be a reasonable charge which would give you more money to do the things that you have to do to deal with this issue.

Early Intervention. We've had lots of conversations about this over the years. And I know you've already had some conversations with some of my colleagues this morning on

it. I just want to chime in and say from anecdotal evidence, I'm hearing there are waiting lists down in my part of the state, down in Westchester County and New York City. I'm hearing that there's a shortage of providers, which is the result of the changes that we've made over the last few years, and I'm very concerned about that.

One of the things I wanted to ask specifically, though, was are the rates in each county determined by some type of a cost of living adjustment?

COMMISSIONER ZUCKER: I will find out about whether it's based on the cost of living.

ASSEMBLYMAN ABINANTI: I haven't been able to get an answer to that. Some staff have tried to look into it and whatever.

But I am told that the cost-of-living adjustment for Westchester is, like in many other situations, a Hudson Valley rate as opposed to a downstate rate. And if you recall when we did the minimum wage, we included Westchester with Long Island, as

opposed to with the rest of the state. I'd like you to look into that.

That might ease a little bit of the burden if we could have a special rate for Westchester similar to Long Island and New York City rather than the rest of the state, because we have such a high cost of living. And there is a great difficulty in getting providers in Westchester County for Early Intervention.

Secondly, again a local issue, I've heard some complaints from some advocates about clean water. They are saying that they're finding that in the Hudson River and on Long Island Sound, that there are high levels of contamination from leaking in sewage treatment plants. And they specifically asked me to ask you, can you improve your partnership with DEC to see if we can deal with these much more quickly. I mean, for example, there's one on Long Island Sound apparently that has been going on for a while. And I don't know if you're familiar with that one.

COMMISSIONER ZUCKER: Well, I will tell you, Assemblyman, I am extremely proud of what the department has done, what the state, the entire state has done on the issue of water. Working closely with Commissioner Seggos -- we chair, both, the Drinking Water Quality Council -- but we have worked on so many areas in this state, both in the areas you have mentioned but also in other parts of the state, to look at contaminants, whether it's contaminants in drinking water -- we've worked on putting the appropriate types of filtration systems in place, we've worked with the counties, the county commissioners, county executives, the mayors of communities to address this issue.

In addition, you know, regarding the Hudson River, Commissioner Seggos and I have spoken a lot about that, about any contaminants in the river. It would probably be better to ask him some of the specifics about what DEC is doing on that.

ASSEMBLYMAN ABINANTI: I will.

COMMISSIONER ZUCKER: But this --

we've had, on the Drinking Water Quality Council, we've had two meetings, we have another one coming up in two weeks from today. We are looking at some of the issues of contaminants, whether it's PFOA, PFOS, 1,4-dioxane. And the Governor had charged us with this a while back, and we have pushed aggressively on this issue for the State of New York.

ASSEMBLYMAN ABINANTI: Thank you.

Now, you also discuss Medicaid coordinators. Do you need a Medicaid coordinator to access services from Medicaid? Because I'm understanding in Westchester County, to access OPWDD services -- which I guess we talk about tomorrow -- you need to have a Medicaid coordinator, and there are none available.

The few that we have have a full slate of people, and there are no Medicaid coordinators. And now we're going off into this new system, and I know of Medicaid coordinators, because I've spoken to some, who are going to be dropping out because they

like providing service, they don't want to be just a coordinator.

DIRECTOR HELGERSON: So I think we're talking specifically about OPWDD and its conversion to managed care or at least health homes and then eventually managed care. I would suggest directing that question to Commissioner Delaney tomorrow. I think she's going to be talking directly to that change. But I think overall -- I mean, we're supporting them as an agency in that effort. But I think she's probably the best one to answer that.

ASSEMBLYMAN ABINANTI: I just want to express the concern to you, because I know it's something that you're dealing with. And like I said, there's a shortage and I think there's a waiting list for them, so that's a lot of people who aren't getting services.

As a last question, what are we doing as a state to increase the number of medical professionals who have a specialty that deals with people with special needs? I know we discussed this last time. I'm out of time,

but I'll just wrap this up. I've met with the psychiatrists in Westchester County. There are very few that take Medicaid, if any at all. There are very few that even deal with children who have special needs. And I know in the rural areas it's even more difficult.

What are we doing to meet the need of people with special needs for all types of medical services? There are very few doctors that actually understand people with special needs and are able to take care of them. I've heard story after story where people with special needs go in to a dentist who claims to know what to do and then they have no idea how to deal with a child with special needs if the child acts a little differently than the normal child and all of a sudden they say, "I'm sorry, I can't treat the child." And the few dentists in Westchester that take kids with special needs don't take Medicaid.

So we have a real crisis for people with special needs trying to access all types

of medical care, from psychiatric to dental to just normal doctors.

COMMISSIONER ZUCKER: So I hear you, and I understand that this is a concern. We will work with the community to try to figure out -- well, two parts. One is how we can get them to either accept more patients, who are specifically the ones that you're referring to, and also to work with the community of not just the doctors and the nurses but other health professionals that could probably provide some of those services.

ASSEMBLYMAN ABINANTI: The only thing I could suggest, if I may, and that is let us take a look at the Medicare rates rather than the Medicaid rates. And maybe if we can make our Medicaid rates closer to the Medicare rates, we might get more doctors doing this.

Thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

CHAIRWOMAN YOUNG: Thank you.

Senator Kaminsky.

SENATOR KAMINSKY: Thank you.

Good afternoon, Commissioner.

Long Islanders remain concerned over 1,4-dioxane. There was some, as you know, expose about a year back about it, and the state jumped on it with an initiative where you partnered with DEC.

Can you please update us in terms of where we are with setting a level for that, as well as the treatment to remove it once a level is set?

COMMISSIONER ZUCKER: Sure. Thank you. And it was a pleasure to be out in the county.

Let me tell you what we are doing. We're doing a lot on this issue. One is -- there's two parts, there's one setting the level and there's another area regarding the filtration system. So we're working with Suffolk County to move forward with the AOP, the Advanced Oxidation Process, oxidated phosphoral relation process, to actually remove the 1,4-dioxane, which is important, obviously, as you're well aware about the plume in that area.

Regarding setting a level, the Governor charged us with the Drinking Water Quality Council and to have meetings to address this. And as I mentioned before, we are meeting on February 26th to get more data about this and we're moving forward on getting MCL levels set. And once I have more information exactly, I'll be able to provide that for you.

But we are aggressively moving forward on this issue.

SENATOR KAMINSKY: Okay. And do you believe it will be set in this calendar year?

COMMISSIONER ZUCKER: I hate to commit to a time or a date. But this is February, so we've got 10 months.

SENATOR KAMINSKY: Okay. A number of advocates have told me they heard that the EPA is moving ahead with setting a limit, after not doing so for a long time. Are you hearing anything about that?

COMMISSIONER ZUCKER: I haven't. Though I am skeptical with this -- with what goes in Washington about where we are on this

now.

On other issues, I had asked the CDC a year ago -- a year ago today or this week -- to set a level, and they didn't. And that's why we ended up saying we will do this. So I am not going to wait for the federal government to do anything on levels of this nature or for many other issues that we have addressed, and we will just move forward, as the State of New York, aggressively to address this.

SENATOR KAMINSKY: Thank you.

Do you have confidence that a filtration system that is cost-effective enough to be used across the state is something that will be forthcoming?

COMMISSIONER ZUCKER: So the AOP system we believe -- well, we know is effective on 1,4-dioxane. And the priorities here is the people of your county and, for that matter, the people of the entire state. And we have worked to address this, whether it's 1,4-dioxane or PFOA or PFOS, and the appropriate filtration systems are being put

into place.

And we're also working to test people. In your area, we actually did also some monitoring as well, not just put the filtration system in, but monitoring of --

SENATOR KAMINSKY: In certain brownfield sites and other places, is that the monitoring you're talking about, from wells in certain brownfield sites or other places? Or you're just -- where are you finding that data?

COMMISSIONER ZUCKER: Well, our team, we have experts to look specifically at the plume -- and this is working with DEC -- to find out exactly where it is. We do monitoring, and I've got some superstar experts in the department, particularly in the water quality part of the department, who will exactly identify what needs to be done on this issue. And we will -- we will tackle it, and that's a commitment.

SENATOR KAMINSKY: Okay, thank you.

Just one last quick thing. I'm from Long Beach, a barrier island that used to

have a hospital and no longer does. And FEMA gave funds to a hospital a little while away, South Nassau, that's supposed to be spending money on Long Beach. We've worked incredibly well with Dan Sheppard and his team from your department, and I would just ask that you continue to make sure that Long Beach receives the funding and medical attention it deserves, so that doctors come back and so that the residents are adequately taken care of, so that Long Beach is not forgotten as we move forward in the process.

COMMISSIONER ZUCKER: Sure. Dan and I spoke about this specific issue recently, and we are -- we will make sure of that.

SENATOR KAMINSKY: Okay, really appreciate that. Thank you.

CHAIRWOMAN YOUNG: Thank you.

CHAIRWOMAN WEINSTEIN: Assemblyman Oaks.

ASSEMBLYMAN OAKS: Yes, Commissioner. While we've been here today, the Governor has announced some of his 30-day amendments. And in that there was the proposal to permanently

authorize pharmacists to do vaccines with children and enable pharmacies to participate in the Vaccines for Children program.

My question is, do you know if there's any money being allocated to train the pharmacists in doing that?

COMMISSIONER ZUCKER: So I will look into how much -- what resources are available.

Obviously this is to expand on the executive order that the Governor put forth about having pharmacists immunize those from two to 18 years of age for flu. And clearly this is a bad flu season this year. This is something which will be extremely beneficial.

I'll look into exactly how much of the resources there will be.

ASSEMBLYMAN OAKS: So part of that would be what are we spending, I guess this year, and then --

COMMISSIONER ZUCKER: Going forward.

ASSEMBLYMAN OAKS: -- for the proposal going forward. And would it be DOH or SED doing that, do you know?

COMMISSIONER ZUCKER: DOH is -- would be involved in this.

I will say that one of the things that we are working hard to do is -- and I raised earlier -- is the need to expand the way care is provided to those in a community, and who else can provide it. And I think here's a good example regarding pharmacists to be able to practice within their -- you know, within their scope of practice be able to do things and to be able to provide immunizations.

If one asked somebody who they see more frequently, I bet you they would tell you they see their pharmacist more frequently than they see their doctor. Because when you walk in there every 30 days or every 60 days -- if you have any prescription, you need to go back in there. So I think that it behooves us to work with pharmacists in so many ways because they may be the person who can identify a problem with a patient and also provide immunizations and other services.

ASSEMBLYMAN OAKS: Moving on to

another issue, last year the commissioner of the State Office for the Aging testified that the New York Connects program is now being funded under the global cap. And just, again, with the federal landscape and whatever, can we be certain that it's going to be funded all right without a specific appropriation?

DIRECTOR HELGERSON: Correct. There are no cuts, there are no changes --

COMMISSIONER ZUCKER: No cuts.

DIRECTOR HELGERSON: -- that funding levels will continue as is, as necessary to meet the needs of the program.

ASSEMBLYMAN OAKS: I appreciate both of your answers. Thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

SENATOR KRUEGER: Senator Tim Kennedy.

SENATOR KENNEDY: Thank you, Commissioner.

I'm very pleased to hear about the Governor's Article VII language regarding the lead paint exposure. And there's areas that require local code enforcement to follow up

with inspections. There are nine zip codes in the City of Buffalo specifically where there are identified areas of high risk. And so I'm curious to know, with this Article VII language, what the Department of Health will do with local code enforcement to ensure proper follow-up when dealing with buildings that are chipping paint.

COMMISSIONER ZUCKER: Right. Well, so the Governor is committed to making sure that when someone buys a new home or -- I'm sure you're familiar with it, buys a new home or -- that they need to make sure that they test it for lead and to be sure that -- and many other real estate transactions in that nature. We -- if they're elevated, obviously we will make sure that this is corrected or push to get it corrected.

I'm not sure, are you concerned that there won't be enough resources? I'm not sure what you're --

SENATOR KENNEDY: Yeah, does the Governor's budget propose any additional funds for enforcement with that Article VII

language?

COMMISSIONER ZUCKER: I'll look and see what we have in the Article VII language on that.

SENATOR KENNEDY: I think it would be essential, especially given the circumstances with the high-risk zip codes that have already been identified. And I think it would help statewide.

But I really appreciate the efforts and the focus on it. As you mentioned during your testimony, individuals that are suffering from lead poisoning are so debilitated that we have an obligation to get out in front of this issue.

COMMISSIONER ZUCKER: I agree. And I will tell you, back in the days when I was an intern, a resident -- this was not in the State of New York, but this was in Baltimore. And there are many children that I actually gave chelation therapy to, and they came in -- and it's a similar situation where lead paint or lead dust -- and it was very disheartening to see the cognitive effects on

children who are exposed to lead, and we need to get on top of it. And we will.

SENATOR KENNEDY: Well, I applaud your efforts.

I want to switch to Western New York and the lack of primary care physicians that are available, and quite frankly the concern that I have, and it's shared in the medical community, of a withering accessibility because of the physician shortage or shortage to come. Statewide, it's 114 primary care physicians per 100,000. Out in Western New York, the number is 90 or even below 90. Which again is a bad trajectory, and especially when we're talking about equitable resources for our communities.

Do you recognize this shortage? Is it a crisis at this point? And what can we do to attract more physicians, especially in areas of upstate New York that need them?

COMMISSIONER ZUCKER: I absolutely recognize this. It is something we're very concerned about. I have a team working on this to try to figure out how do you get

health professionals -- whether it's physicians, nurses, pharmacists, as we were just talking about -- into an area.

So what are some of the incentives that we could put into place to do this? And this is where we're looking across the board. Sometimes this is not necessarily the things that you naturally think about. There must be some creative solutions, whether it deals with real estate, whether it deals with schools, whether it deals with communities, whether it deals with training. You know, Buffalo has a medical center there, a medical school there. How do you get doctors to stay in the area who are coming out of there?

Another thing that we've spoken about over the course of the past year is there are many graduating medical students and residents who also want to run off to other parts of the world and provide care.

And I say that some of the challenges that you see in other parts, having traveled the world to different areas, it's an issue of rural health. That's what it is. It's an

issue of not having one doctor or one person over a large area. You could do that right here in New York, you can go to certain areas.

So how do we keep them right here in the state and not, say, run across the world?

SENATOR KENNEDY: So there's a doctor that I had met with a couple of weeks ago, part of a group that I've been meeting with on issues like this, who told me that his caseload is 10,000 patients. And that is not a rarity, especially in upstate areas, in rural areas, but it's not confined just to the rural areas of upstate New York. There are true needs that are, to me, going unmet because of this shortage.

And it seems like there's a bit of a tsunami coming, a wave coming, where there's going to be many doctors that are retiring. And I think at this particular point, we're not prepared to address it. I think we have to address it.

To your point, and I appreciate the fact that you have a team that's looking into

it, I think we have to prioritize this. There are a number of ways, whether it's scholarship-based, to keep them in the state.

COMMISSIONER ZUCKER: Right. So we -- there's two parts to that. One is what do we do with the students.

So I just met with one of the deans of one of the medical schools here in the state a couple of weeks ago, and we were talking about this exact issue about how do you keep people -- what are the incentives, whether, again, it's tuition, issues of tuition reimbursement, other ways to bring them into the medical school and to say this is something we'd like to be sure that you're committed to. That's one part.

And then the other part is when you say about a doctor who has 10,000 patients, it goes back to some of the other things we spoke about, which is who else can provide some of the care. So when we were talking about retail practices or about pharmacists doing things, or nurse practitioners, this is part of the reason, to try to sort of offset

the unbelievable demand that's being put upon some of the doctors. That doesn't solve the problem of what you're saying about increasing the number of physicians in the state.

We're working on it from both ends. One is patient care, how do you make sure that patients get -- don't end up with a five-minute visit. And then the other issue is about how do you get more doctors into the area. So I am absolutely pushing this issue, and we're trying to figure out how to solve it.

SENATOR KENNEDY: So I look forward to working with you on that, and I would commit to working with your team to address this in upstate.

That being said -- and I'll close on this -- the New York State 30 program, obviously driven by the federal government and the ability for doctors to work with visas in this country, but in each state we are given 30. In New York State, with a population of 20 million people, 30 more

doctors is a drop in the bucket. So we need more.

But I'm concerned that those 30 aren't making their way out to Western New York and upstate. And so I'd like a commitment to getting a more equitable distribution of where these doctors are actually located as part of the New York State 30 program.

COMMISSIONER ZUCKER: And we're working with these program doctors across New York, and I hear what you're saying, make sure there's more equity.

One other thing I just will add that I have done, is I actually spoke to my fellow commissioners around the country, because upstate New York is as rural as some other parts of the United States. And so I asked them, what do you do to get doctors into other areas? So we had a little discussion about that also, to try to apply some of the things that are being done in other parts of America to right here in New York to try to solve this problem.

SENATOR KENNEDY: Great. And again,

driven out of what's happening in Washington with the immigration issue, I know that this has to be a part of that.

COMMISSIONER ZUCKER: Yes.

SENATOR KENNEDY: However, given what we are allowed to deal with with the 30, I would definitely like to work on that with you as well.

COMMISSIONER ZUCKER: We surely will. And I promise you I will push that.

SENATOR KENNEDY: Thank you.

CHAIRWOMAN WEINSTEIN: Thank you, Commissioner.

I have a few questions. A topic that hasn't been raised here is the proposal to reduce the spousal resource allowance as relates to, well, spousal and parental impoverishment issues. I was very pleased -- more than 20 years ago, I was there for the announcement when New York State adopted the spousal impoverishment level at $74,000, a level we haven't changed for inflation.

So now the Governor's proposal would reduce that to the bare minimum, reduce that

amount to the bare minimum of 24,180. And I'm very concerned about this issue, which is truly an older women's issue. So I was wondering what impact would eliminating spousal refusal have on spouses that continue to reside in the community, also families of a severely ill child, and how many individuals would be affected by these proposals?

DIRECTOR HELGERSON: Certainly. Appreciate the opportunity to answer this question.

So the challenge I think we have today and I think we are going to have as a state over the next multiple years -- decade, perhaps -- is the growing cost of long-term care. Many of us have predicted that a demographic wave was going to hit states and state Medicaid programs as a result of the aging of the baby boom generation and the increased demands that that very large generation and its aging would affect the long-term care system.

We are beginning to see now evidence

in New York State Medicaid of that wave actually coming to our shores. And it's now the number-one driver of costs in New York State Medicaid, is the growing number of individuals who are coming to the program in need of these services.

We the state, through a contractor, assess the eligibility, the needs of these individuals -- do they really rise to a level of need that they need to be enrolled in programs like managed long-term care, and we have a high degree of confidence that they do need, because we control that process.

But what we're -- and that's why you see in our budget proposal a series of things designed to potentially stem the growth in costs in that sector, whether that's directing our high-touch care management programs towards the individuals who need it the most, whether that's our nursing home proposal designed to make sure we don't pay for care management twice for someone who's in a permanent nursing home setting, or the proposal you flagged, which is designed in

essence to try to keep as much private money in the system as we can.

I think we're just going to be facing this issue going forward. New York does not -- and I think we should be proud of the fact -- have other limits on growth in the program that other states do. Very common policy that you'd find in almost any state in the country outside of New York is a cap on the number of slots for home- and community-based services. We do not have those caps. Services like personal care are an entitlement -- if you need it, you can get it.

That means that we are more susceptible to this wave coming to our shore than other states are. But I can tell you it is now a major driver of costs, not just here but in other states. But the proposals that are made are in essence designed to try to keep as much private money in the system as possible so we can really focus the Medicaid dollars on the populations who need it most.

CHAIRWOMAN WEINSTEIN: As you know,

before we established the community resource levels, the advice we would give a couple facing -- with one spouse, so often the husband, facing high need for whether nursing home care or care at home, was -- the only solution the state offered was get a divorce. And then the sick person could qualify, and the well spouse -- again, so often the woman -- would be able to retain enough income to be able to stay in the community. And I hope we're not heading in that direction again, because the system has worked well in the past.

To just follow up a little bit of what Senator Savino said about home -- was talking about home healthcare workers, one of the issues that I find in my community, and it's an issue that I've heard about, is clients who are eligible for additional hours but not being able to -- and have been approved for a certain number of hours, not being able to get the hours that they are eligible for and in need of because of healthcare worker shortages.

And I was wondering if there's anything in this budget that starts to address that issue.

DIRECTOR HELGERSON: So what is true is that with the growth of managed long-term care and the move statewide, through the Medicaid program, at least, we're providing more home- and community-based services than ever before. So there's been a rapid growth in that.

And that has just put stresses on the workforce, particularly in rural areas where we simply -- in the past, in many of these communities, the only option was a nursing home. Now we've created doors to home- and community-based services.

But I do think this gets back to this whole issue too of this demographic wave that is now beginning to affect us. It's putting stress on the system overall. I think one of the things -- and that's why you see the ALP proposal in the Governor's budget, is we do need to think about creative ways to expand the continuum of services, to think about

what we can do to provide services in cost-effective ways. I think it's going to be one of -- this whole question around long-term care, how do we finance it, how do we provide it, I think honestly is going to be the -- it's going to dominate the debate in Medicaid for the next 10 years. At least that would be my humble prediction, because I just think that it's going to be a challenging issue and each year it's going to become more challenging.

I think that increasing the wages, the minimum wage, helps. We have dollars set aside, some waiver funds, to provide additional training opportunities for individuals.

But that said, I think it's just going to be one of those things we're just going to have to grapple with going forward.

CHAIRWOMAN WEINSTEIN: Thank you.

And Dr. Zucker, an issue that -- a concern that we've spoken about that is shared by not only my colleagues from Brooklyn, but others around the state, is the

Governor's proposal to change the $78 million of operating funds for the SUNY hospitals to capital.

Particularly I'm concerned about the -- what I understand is over a $30 million impact to Downstate. That's just with the change from operating to capital; that doesn't even start to address the ongoing issues with Downstate and the need for additional operating resources because of their patient base.

COMMISSIONER ZUCKER: We are looking at all of the State University systems, the medical systems that we are responsible for to be sure that there are resources both for operating as well as obviously the capital.

I think that -- we are working closely with -- I know Downstate has raised this issue, and we are working closely with them to be sure that what their needs are that they have are being met, both from capital as well as clearly the operating aspect.

CHAIRWOMAN WEINSTEIN: Well, anything that the Brooklyn delegation can do to help,

within reason, we are there, because we're very concerned about the situation.

COMMISSIONER ZUCKER: I will be going down to talk to Downstate at some point in the near future to address these concerns and other concerns that they have.

CHAIRWOMAN WEINSTEIN: Thank you.

CHAIRWOMAN YOUNG: Thank you.

A lot of good discussion today, and I want to thank you for that. But there are some follow-up questions that I have. The first has to do with the Fidelis conversion from nonprofit to for-profit with turning it into Centene. So that deal, if it's made, would have to be approved by the Attorney General, the Commissioner of Health, and also DFS. And one of the questions I have -- have you gotten any assurances from Centene that the same geographical area will be covered that is currently covered by Fidelis, in order to ensure network adequacy?

COMMISSIONER ZUCKER: So our department and DFS are looking closely at the sale and the assets to see where it's going

to make sure that the patients are taken care of and also look at the providers and who's going to provide -- who's going to be -- where that's going to be distributed across the area.

DIRECTOR HELGERSON: Could I just add to that. Whether it's Fidelis or whether it's Centene or it's some other plan, they have to meet the same contract requirements for Medicaid in the Essential Plan. And so regardless of who operates it, those contract requirements do not change.

CHAIRWOMAN YOUNG: Thank you.

So what you're saying is that if a rural area already is covered, you are assuring us that that area will still be covered under the new contract?

DIRECTOR HELGERSON: The only option any plan has is to expand or retract its overall network, meaning you have to exit or enter a new county. But there's a whole process by which a plan would have to go about that.

But in terms of where they're

accessing and the network adequacy standards that we hold plans accountable to, all plans, regardless of who the owner of the plan is, those requirements are standard across all managed care organizations that participate in the Medicaid program.

CHAIRWOMAN YOUNG: For how long would that assurance be in place?

DIRECTOR HELGERSON: Those contract requirements are permanent features of the contracts that those plans sign. So there is no time limit on them.

CHAIRWOMAN YOUNG: Okay, thank you.

Now I want to switch gears just a little bit. You've seen that there's a lot of interest from the legislators regarding the lead paint issue, the lead issue in general. As we know, Mayor de Blasio came in under Local Governments and had to testify about the New York City Housing Authority and the scandal that exists there.

So you've given some answers, but I really would like to get into specifics. And if you could give us some specific

information, that would be very, very helpful.

How many municipalities are designated as high risk?

COMMISSIONER ZUCKER: So with regards to this, what we're going to do is, as Senator Sanders asked me whether we will investigate this, we will investigate this issue. And I have to sit down and determine the scope of this entire problem. And as I promised him I will do, we will look at that and we will look at all the issues -- not just lead, but we'll look at issues of mold and other problems. But I have to find out what the numbers are.

CHAIRWOMAN YOUNG: Thank you.

And would New York City, in your opinion, be subject to this if this provision becomes law?

COMMISSIONER ZUCKER: Well, we're going to go in -- it's -- as I understand from the Senator, it's the issue of NYCHA, and we will investigate that and find out what's happening.

CHAIRWOMAN YOUNG: But I think that the -- it's NYCHA and I agree with that wholeheartedly, but are there -- there must be other municipalities around the state that would have to be included with that information.

COMMISSIONER ZUCKER: Right. So we will look -- I understand what your question is about other counties. We will look and see -- when I sit down and look at this, I will look at the scope and try to get a sense of where else in the state there's a problem.

CHAIRWOMAN YOUNG: So obviously this is a big issue. But as you look at that, could you also let the Legislature know, do you anticipate a fiscal impact on any municipality that may have a lead paint problem? Because obviously this could get to be quite expensive if there has to be abatement.

COMMISSIONER ZUCKER: Well, let me -- I'll get back to you on that.

CHAIRWOMAN YOUNG: If you could include all that, that would be helpful.

Also just on the lead issue, we also have issues in our water systems, as you know. And the New York Clean Water Infrastructure Act of 2017 implemented the lead service line replacement program, which awarded $20 million to municipalities to replace water lines in order to reduce the risk of the amount of lead in drinking water.

And so the Department of Health was, under statute, required to equitably distribute funds among regions of the state. Within each region, they were to give priority to municipalities that have a high percentage of elevated childhood blood lead levels based on the most recent data.

So were there municipalities that met the eligibility threshold but did not receive any awards?

COMMISSIONER ZUCKER: I'm not clear exactly what you're asking me on this.

CHAIRWOMAN YOUNG: So $20 million was in last year's budget for -- actually, it was in 2017. Yeah, it was the 2017 budget. It was supposed to be distributed regionally,

equitably, and there were several awards that went out.

My question is, though, is the problem bigger than the awards that went out? And how many municipalities do we have in the state where they may have the same issue, may be facing the high childhood blood lead levels, and yet they didn't get an award?

COMMISSIONER ZUCKER: So two parts. One is that we obviously go in and look -- if there's any concern with a child with an elevated lead level, we will go in there. Obviously there's also a program to look at the lead pipes that are going into facilities.

Regarding specific municipalities, I will find out for you what are the numbers in these municipalities and what are the costs that have been provided to those municipalities.

CHAIRWOMAN YOUNG: Thank you for that, Commissioner. You know, I have this list here, it's 12 pages single-spaced. To my understanding, these are municipalities,

localities that have lead problems that it just hasn't been addressed. There's some in my district, but they're all over the state.

I think we need a plan, quite frankly, to deal with this. Because obviously the implications of having childhood lead poisoning are enormous, not only because of the impact on lives, but obviously there's a cost to the system too. And we want to make sure that every child is protected from this, and every person, frankly.

So if we could get some more information on that, that would be very helpful.

Finally, I just want to ask -- and we touched on it a little bit, but with the opioid and heroin crisis, DOH actually publishes the incidence of newborns being born addicted to opioids. Unfortunately, as you look at those statistics, they're staggering, number one.

And number two, for example, Chautauqua County, in my district, has very, very high rates. And I was wondering if

there's anything included under the Governor's budget proposal to deal specifically with newborns who have this problem.

COMMISSIONER ZUCKER: So we are looking at the opioid issue across the board, not just those who are adults. But we're working on issues of education and how to communicate with both health professionals and also the public in general about the dangers of opioid addiction.

The -- I can't give you an exact number of how much money is being put towards that, but I can promise you that we are trying to make sure that this education is out there both to the community.

CHAIRWOMAN YOUNG: Thank you. But you know, my understanding, and I've talked to health professionals, newborns that are born addicted oftentimes do not present any kind of -- anything that would indicate to a physician that the baby has a problem and it is addicted. Is that correct?

COMMISSIONER ZUCKER: So I will tell

you, as a pediatrician, I've seen unfortunately a lot of children who were born to addicted moms, and they literally do go through a withdrawal process right there in that nursery, and unfortunately many times in the intensive care unit. And this is -- it's just -- it's actually heartbreaking to watch a little day-old, two-day-old, three-day-old, four-day-old baby go through this.

So the key here is, one, getting the mom treated and addressing this issue early on, even before her pregnancy, and then to get them into a health system to make sure that this child is cared for immediately at the time of birth.

There are a lot of other issues that come along with a mom who is addicted to drugs -- prematurity and all the other issues, whether it's cognitive issues or other problems that occur. And I think that is important on the part of the Health Department to tackle this.

CHAIRWOMAN YOUNG: Do all babies present the symptoms immediately, or

sometimes is there a delay?

COMMISSIONER ZUCKER: Well, usually they present relatively early on. Again, it depends on how severe the mom's addiction is. So if she's significantly addicted to drugs, the kid is going to go through withdrawal, and perhaps a little bit delayed. But if you're talking about delayed by months or longer --

CHAIRWOMAN YOUNG: No, I'm talking about like, say -- for example, could the baby potentially go home and the doctor not be aware that the baby is addicted, and then the baby goes through withdrawal at home?

COMMISSIONER ZUCKER: So that brings up a very good point. Because if you have a mother who is addicted and you don't know that, and you have the child in the hospital and say it's a vaginal delivery and she goes home in 24, 48 hours, yes, they can end up presenting with a problem and be rushed back to the hospital.

And then here's where your issue is, that what if they don't have a health system

that they are part of, or a healthcare provider that cares for their child, then they're left at home.

So I think that that brings up the issue of what else we can do to make sure this information -- that child is cared for. One is to get the information from the mother up-front about whether there's any issue of addiction. And number two, to figure out very early on if there's a problem, as best as one can pick it up. Usually it's relatively early. But again, we send kids home relatively quickly, so it could be that this withdrawal will occur at home.

CHAIRWOMAN YOUNG: Right. Which could be very dangerous to the infant, number one.

COMMISSIONER ZUCKER: Sure.

CHAIRWOMAN YOUNG: And number two, it's a very bad combination to have an addicted mother with a screaming baby going through withdrawal.

COMMISSIONER ZUCKER: Right. So then again, this goes back to education, not just education to the mom but also education to

those in the community. Because maybe someone will be able to say to the mom, I'm concerned about your baby.

CHAIRWOMAN YOUNG: Now, we test, Dr. Zucker, for more than 40 things, I believe, at birth.

COMMISSIONER ZUCKER: Forty-seven.

CHAIRWOMAN YOUNG: Forty-seven. Should we test for opioids at birth?

COMMISSIONER ZUCKER: So I guess what we do is the tests that we do are sort of for things like PQU, maple syrup urine disease, different types of tests. And these are blood tests. And usually a lot of the opioids are urine tests. So it brings up a different issue about what to do.

That would be a big -- let me think a little bit more about what the best way to approach this is to make sure these babies are not at risk.

CHAIRWOMAN YOUNG: Thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

Assemblyman Gottfried.

ASSEMBLYMAN GOTTFRIED: Yes. So

before I ask a couple more questions of Jason Helgerson, Dr. Zucker, I just wanted to go back to the earlier question about the CRNA legislation, and not so much ask a question as if I may presume to sort of expand on your response, which is that what the legislation in the budget is aimed at doing is codifying the terms under which CRNAs have been practicing in New York, I think very successfully, for decades. And I think the language that's in the budget bill is a major step in that direction and a very welcome one, from my viewpoint.

Question, Jason. You know, last year the Executive agreed to work to create a system of MLTC payment to provide a higher rate of payment to plans for patients that require a higher degree of care. This is especially important in home care. You know, the goal is to reduce the incentive for MLTCs to avoid serving those patients and to reduce the financial penalty on them if they do serve them.

And so my question is: It's a year

later, how is that effort coming?

DIRECTOR HELGERSON: Sure. So we have submitted to CMS white papers for their consideration. So it's definitely still a work in progress. But we remain committed to seeing if we can get federal approval.

There was an issue, and I think we raised this up-front, that CMS initially had said no to efforts that, for instance, have a separate rate cell for nursing home care or they've raised concerns about separate funds or separate rate cells specifically for quote, unquote, high-cost individuals, unquote.

But we are back and forth with them on the issue, so it's still a work in progress, but still remains a priority for us to try to get done.

ASSEMBLYMAN GOTTFRIED: Thank you.

And you talked about this a little earlier. You know, we've talked several times at these hearings and elsewhere about the question of managed care plans negotiating their own drug prices versus

having the department take that role back. Which the department did, you know, before 2012.

And in the past you've talked about how managed-care plans are better able to negotiate prices because they use large PBMs. I think we've been seeing and widely recognizing in the last couple of years that there are a lot of problems with PBMs.

In the discussion of the Medicaid drug cap, you said that the mere threat, really, of the department coming in to negotiate drug prices has convinced a lot of drug companies to lower their prices. And it seems to me that if, you know, essentially having just you glare at them without having to, you know, draw your gun gets us lower prices, it seems to me that we ought to be able to get a lot better deals if instead of putting negotiations for drug prices in the hands of very problematic PBMs, it was back in the hands of the department.

DIRECTOR HELGERSON: What I would say is that the additional rebate agreements that

we've been able to reach, first off, they build off of the agreements already reached by the PBMs through our health plan partners. So we're basically looking for supplemental rebates on top of the base agreements that have already been reached. So the fact that they have that negotiating power is helpful. And I think we're looking to, you know, just build upon that.

The second piece in that, I think that what the legislation gave us that was really the most powerful tool in the toolkit here to get compliance was disclosure.

If you remember, in the agreement that was reached between the three parties was that this would be a highly targeted initiative that would target a subset of drugs and a subset of manufacturers -- basically, the drugs that were really driving costs above the cap -- and if the manufacturer wasn't willing to come forward with a lower price, one of the big tools would be that the department could basically require a much greater level of disclosure

from the manufacturer relative to their pricing behaviors and things like that.

I think -- this is just my own perception of how this went -- was I think that threat was very powerful.

Now, the question is could you really apply that threat across all drugs, all manufacturers. There's thousands and thousands of medications. We don't have the resources to apply that kind of rigor to it, and probably that kind of threat wouldn't be appropriate outside of these specific drugs that were driving us to higher levels of spending than we could afford.

So I think at the end of the day it -- I think it's a powerful new set of tools. I think overall it's giving the department, in collaboration with the plans and PBMs, the right mix of tools to be able to effectively manage drug prices.

The last thing I would say on drug prices, the biggest challenge we now have is just a lack of certainty about what is in the pipeline of new drugs. And I think that --

well, I mentioned managed long-term care as the major driver at the moment. We do fear the prices coming down the line for some of the new gene therapies, for instance, or some of the new drugs, they're highly specialized, they target a very small number of individuals. But our experience even with just two that we've grappled with in gene therapy is they're half a million dollars per patient per treatment.

It does not take a large number of those to come in. And there isn't a lot of transparency into that. It's gotten us to the point now that we're actually looking overseas to potential partnerships with NICE, in the United Kingdom, for better information about what's in that pipeline. Because that is, I think, one of the things that really has us concerned in the future is these highly, highly specialized drugs and where they are and how much they're going to cost.

ASSEMBLYMAN GOTTFRIED: My last question is the Executive Budget proposes to raise the cap on the number of visits for

physical therapy from 20 to 40, which to me is a welcome step in the right direction. But in the same provision it takes the 20-visit caps for occupational therapy and speech therapy, which are now 20 of each, and says you can -- that you can have 20 of the two taken together. So if you need 11 occupational therapy visits and 11 speech therapy visits, you're out of luck.

In a state where we have a constitutional mandate to base the Medicaid program on a standard of need, what is the justification for linking your entitlement to OT visits or speech therapy visits to whether you've used the other one?

DIRECTOR HELGERSON: Sure. So we've had a cap -- I think the cap on those types of services dates back to the very first MRT set of recommendations.

I mean, the purpose of this proposal is actually to give greater flexibility, so I'm happy to go back and look at the statute. But that clearly was the intent. And if you see that there's actually an investment on

the global cap scorecard for this item, that we actually expect to spend more money because we expect there to be more therapy services provided.

But I'll take another look at the statute to see if there's some reason, something that's inconsistent with that objective.

ASSEMBLYMAN GOTTFRIED: Well, if the intent is that you've got 20 of this kind, 20 of that kind, if you want to switch from one kind to another, you can do that. The way to do that would be to say you've got up to 40 visits of OT or speech therapy, not 20. So if that's the intent, whoever drafted the language has done the opposite.

DIRECTOR HELGERSON: We will take a look at that and get back to you.

ASSEMBLYMAN GOTTFRIED: Okay, thank you.

SENATOR HANNON: Senator David Valesky.

SENATOR VALESKY: Thank you, Senator Hannon.

A quick question, Commissioner. I believe it was Senator Young who brought up the issue of drinking water, the public drinking water supply. As you know, I represent the City of Syracuse, which receives its drinking water from Skaneateles Lake. Last summer it had a significant issue in regard to the algal bloom.

I know the Governor has proposed I think it's $65 million to develop an action plan to attack that issue at I think 12 different lakes across upstate New York. Is your department involved in that effort? Is that only a DEC effort? If in fact you are involved, in what way? And what is the --

COMMISSIONER ZUCKER: I believe we are. I will get that.

SENATOR VALESKY: If you -- okay. I'd appreciate hearing. Okay, thank you.

CHAIRWOMAN WEINSTEIN: To Assemblyman Phil Steck for a quick question also.

ASSEMBLYMAN STECK: Does the legislation on CRNAs just reflect how they have been practicing to date, or does it give

them a new ability to practice independently of physicians? And if the latter, what is the reason for giving them more independence of physicians?

COMMISSIONER ZUCKER: So it allows them to practice within -- well, it allows them to work within their scope of practice. And for Article 28 facilities, there should be physician supervision, which is what's written in there.

ASSEMBLYMAN STECK: Did you -- I missed the last part.

COMMISSIONER ZUCKER: So it says a qualified physician would have to provide oversight of the anesthesia services in an Article 28 facility or in any office-based settings.

ASSEMBLYMAN STECK: Okay, thank you.

SENATOR HANNON: Senator Rivera.

SENATOR RIVERA: Thank you, Senator Hannon.

So I had to slip out really quickly, so you might have been asked about these two things, but there's two things that I have

not heard anything about and I wanted to ask you.

First of all, enhanced rental assistance. If I'm not mistaken, in this current budget there is enhanced rental assistance for about 3700 folks outside of New York City. I wanted to see from either of you, probably from Helgerson, about how much you think this is saving us. This is obviously a strategy that you agree with, I hope. And for the record, what do you think it does as far as saving us money for these types of HIV patients?

DIRECTOR HELGERSON: Okay, so -- I gotcha. So we're talking about AIDS/HIV patients and the rental cap.

SENATOR RIVERA: That is correct.

DIRECTOR HELGERSON: So the Governor's proposal, I think it was in last year's budget, basically expanded the rent cap in New York City, with funding from the state and the municipality. We think at the end of the day individuals having access to housing -- we're big fans of housing access

and housing, in our view, is healthcare. And so we're open to any and all ideas for how we can achieve it.

I think the concern is is that while we had a willing partner in the city willing to put up money, I think the concern was would upstate counties or municipalities be willing to put up funds to cover historically what is the local share.

I think we've certainly heard, and we're open to, the argument around could we book some savings within Medicaid from that housing. The one thing about the AIDS/HIV population that can be a little challenging is just that in order to -- active treatment means active use of antiretrovirals, which are fairly expensive. And while we've been successful in negotiating some volume-based discounts, there's still pretty significant expense there, so that cuts into what otherwise would be savings from the initiative.

But I think we remain very open to ideas about what we can do to expand rental

assistance for that population, particularly in light of the effort to end the AIDS epidemic.

SENATOR RIVERA: Gotcha. And last but not least, hep C. As you just were talking about ending the AIDS epidemic, I'm certainly thankful for the Governor and for your work, both of you and your agencies, on dealing with this, trying to make sure that by 2020 we are done with new HIV infections. And we certainly lengthen the lives of those folks who are HIV-positive.

But obviously there are -- as I'm sure that you're aware, if we're talking about hepatitis C, there is a rise in this across the state. And it is a curable disease. I understand that it is expensive. But I wanted to just ask, so it's on the record, what are some of the things that the state is doing? I didn't see much in this budget related to education around hep C. But if you could talk a little bit about what generally the state is doing to address this concern going forward, and particularly with

folks that are already carrying the disease and can be cured. So I wanted to be on the record with that.

COMMISSIONER ZUCKER: So there's two parts to that. One is the issue of what we're doing. We are actually quite aggressive on the issue of education about prevention of hepatitis C. We're working with the community, and this is -- we've had several meetings on this issue as well.

I think one of the other challenges is what you just mentioned about treatment, because there is a treatment for it, which goes back to the issue that Jason brought up before, the cost. That was one of those treatments that is quite costly. It's a challenge for Medicaid on this. But you can address -- Jason will address exactly what we're doing to cover that.

DIRECTOR HELGERSON: Right. I think that one of the things we've been trying to do in Medicaid, and it was a little bit of a challenge with the treatment for hepatitis C, was to keep up with the science relative to

coverage policies. But we've got very open access now.

The good news is that we now have multiple drugs. One of the reasons why it was so expensive up-front was we had one manufacturer with one drug, and they had an ability and they used that ability to drive an, in our view, outrageously high price. The market now is beginning to become more like a market with multiple manufacturers. That hasn't completely played itself out yet, in the sense that -- but we do anticipate that at some point, probably this summer, prices will begin to stabilize and hopefully we'll see the full benefit of those lower prices.

It was an extremely expensive development for the Medicaid program. It literally affected the fiscal position of multiple of our managed-care plans, put some of them at risk of becoming insolvent, even. Now a lot of those pressures have, as the prices have come down, mitigated.

But that said, one of the things we

are open to is a conversation about -- we already have statutory authority to look at volume-based discounts. And so one of the things we're going to do is, once the prices have stabilized, is to look at possibly utilizing that statutory language to see if we can't get ourselves an even lower price, which makes it even easier for us to actively promote the treatment.

SENATOR RIVERA: I certainly hope that you do, considering that it is a curable disease. And obviously it costs us a lot more to make sure that -- if we don't cure these folks.

DIRECTOR HELGERSON: Correct.

SENATOR RIVERA: Thank you so much.

CHAIRWOMAN WEINSTEIN: Thank you.

Assemblyman Cahill.

ASSEMBLYMAN CAHILL: Gentlemen, first of all, thank you. I think it's four hours right now for you. That's pretty good.

Two quick things; I'll try to make them very, very brief -- one maybe not even for the purposes of a response at this time,

maybe you can send me something.

Dr. Zucker, you've testified that the minute clinics will free up primary care doctors so that they can spend more time with their patients. My recollection from talking to folks in the medical profession, it's not -- the doctor shortage is not about how much time they spend with patients, it's about who's willing to become a primary care doctor, because the economics don't work.

How does taking another 5, 10, $15 million out of the primary care economy help them to do a better job and for us to attract more doctors to this community? In fact, it would seem to me that it would have the opposite effect. So you can send me that response when you send me the stuff on EI.

The next one was on the American Lung Association's rating of New York State, which differs somewhat from yours. They certainly did give us an A for smoke-free workplaces. We got an A for that. We got a B for taxes. We're second-best in the country, I guess after Connecticut. We got a C for

programming, and we got a D for regulation.

This is a budget hearing, and it's about funding. Unfortunately, they gave us an F for funding. Has anything changed since January 29th when they issued that report that would give you a different assessment than their assessment of how the programs are working out in New York State?

COMMISSIONER ZUCKER: Well, I will get back to you on those issues.

With regards to the regulation, this is part of what we're trying to do with our regulatory reform issues, to try to get this to move forward to not end up with a D on any kind of issues of regulation.

ASSEMBLYMAN CAHILL: Is the department going to propose a 21-year-old smoking age as a program bill?

COMMISSIONER ZUCKER: We are looking at that. We are looking at that.

ASSEMBLYMAN CAHILL: Thank you, Doctor.

CHAIRWOMAN WEINSTEIN: Thank you.

SENATOR HANNON: Senator Krueger.

SENATOR KRUEGER: Thank you. Just a few quick follow-ups.

Nobody has asked you yet about funding for stem cell research. There were commitments made by the state back in 2017. Then we learned that the money wasn't being released because of concerns about future uncertainty in Washington. Are we ever going to give the $6.5 million that we already committed to the groups? And can we expect any future funding for stem cell research?

COMMISSIONER ZUCKER: There was money that was released, there was money that went out to the stem cell research for what was being provided to a certain point. The issue was going forward from that point after that.

SENATOR KRUEGER: But you approved money going forward.

COMMISSIONER ZUCKER: Right. Right. Right. And so we are looking -- I recognize the issues of stem cell research and I have spoken to many of these stem cell research scientists about this. This is one of the -- it goes back to the issue I brought up before

about a tough budget season, about priorities. It's not that stem cells isn't a priority. We're trying to figure out how to make this move forward.

But we did provide funds to the stem cell research to a certain point, and we will examine it from that point forward.

SENATOR KRUEGER: So you're not giving me an answer now whether the '18-'19 budget includes that 6.5 million that was in the '17-'18 budget that you awarded but never released?

COMMISSIONER ZUCKER: I think that we were moving forward towards that, and I will get you an answer about that.

SENATOR KRUEGER: And I'm sorry, I'm taking the lead of my colleague here that my numbers may be wrong, that there was a lot more than 6.5 that didn't go out?

COMMISSIONER ZUCKER: That money has gone out, the money from '17-'18. And the additional money has gone out. And what happens going forward, I will find out for you where we go with that.

SENATOR KRUEGER: Okay, thank you.

And this is more of a -- I guess it's a Jason question, sort of more of a global question.

So the answer to many, many questions today has been, well, we started something and it was successful, so the costs went up, so now we have to rein the costs in.

Well, didn't we think that if it was going to be a successful program, i.e., expanding access to primary care physicians, that you would see increased costs? Because we thought that was a good thing to direct people into primary care and would hopefully decrease costs down the line in more expensive care.

And then we heard that we've seen expansion in costs for dealing with the long-term elderly. Well, because the demographics, as you said, is we're a growing population of long-term elderly, and we now see people having a 35-year life span from the date we first call them elderly.

So it just doesn't seem to me that the

right punch line each year can be for us to say more people need these services so we're just cutting back on how much we give everyone. It seems like I need a better answer for going forward.

DIRECTOR HELGERSON: Well, in terms of long-term care, it's growing at about the tune of almost like a billion dollars a year. So -- and we've looked at this a number of ways.

One of the concerns was the people who are enrolling, are they really disabled enough to justify this level of service, meaning are they really eligible for the programs, how are they coming to the programs. There's a number of proposals designed to make sure that individuals aren't being inappropriately referred or that there's inappropriate advertising or different things out there.

But we think that the vast majority of the growth we are now seeing is this demographic wave. And as I say, many of us have predicted but weren't exactly sure when

it would come. And New York many, many years ago made a decision to make an entitlement level of service, home- and community-based services. And so as a result, that makes us especially susceptible to this rapid growth.

And I think what we're saying is that, you know, this is not going to be a problem that's a one-year phenomenon, it's going to be something we're going to have to grapple with. And I think the best overall response is to figure out how we can provide home- and community-based or, more generally, long-term care services as cost-effectively as possible.

And I think that's where we need to think about expanding the continuum of services. We need to think about -- back to Dr. Zucker's point about telehealth and teletherapy, can we find ways to support people in the home that doesn't require an aide in the home as many hours as historically has been the case. I just think we're going to be stretched, not only financially, the state, not only -- you know,

there's the cost within the global cap, there's the cost that's associated with implementing the $15 minimum wage. All those things add up to a tremendous level of increased investment that are going into these sectors in this budget, previous budget, and then the future budgets.

So I just think it's going to be a global challenge that we're going to have to grapple with, where we're going to have to really think creatively about how do we meet the needs of people in the most cost-effective setting possible, how are we going to be able to leverage family supports, how are we going to be able to keep as much private money in the system. Many of the things we tried in the past, like long-term-care insurance, have not been as effective as we would have liked. It is a challenge that we're going to grapple with.

I'll give you an example of the kind of creative thinking we may need to do. The oldest society on the planet is Japan, and they have felt the full impacts of an aged

population and a much smaller group, a demographic to support those elders in their communities. And they have come up with some pretty creative solutions, one of which is that they actually -- families actually pay postmen and -women to check in on loved ones as part of their route. They're trained by the government to look for signs of dementia or other decline, to identify potential causes of falls and other types of issues. But they're leveraging that workforce to look out for elders in communities where there aren't just physically enough people in those communities to look after those people.

So I think there's other models across the world that we're going to have to look at, because the pressure that we're now seeing is not going to go away any time soon.

COMMISSIONER ZUCKER: Senator, also on this, we have a team working on this issue about looking at technologies. It is possible that a simple technology that could be out there that could keep people at home is -- will be able to be created or invented.

And we have a team looking at this as a HeroX project that we're doing. We have a group looking at all the issues of long-term care. We have a manual that we're putting out about home care for family members who are providing home care.

And I think that the solutions are going to be a lot more creative than the standard ones that we usually come up with.

SENATOR KRUEGER: So no disrespect to Japan, but I read that New York Times story about what's happening for seniors in Japan, and they're all dying by themselves in empty buildings. So I'm not really sure -- and the neighbors have a deal where you raise the curtains to confirm that your neighbor is alive. And if you don't, you call someone to go get the body.

So I'm not sure I really want us to look at that model as our future for seniors in the State of New York. So read the Times story before you go down that road too far.

Thank you.

CHAIRWOMAN WEINSTEIN: Assemblyman

Raia.

ASSEMBLYMAN RAIA: Thank you very much.

Speed round. Okay, a couple of things on hospitals. I see the emergency room proposal is back, the potentially preventable emergency room visits. I thought we rejected that for a two-year period last year. Guess not?

DIRECTOR HELGERSON: So what we're proposing is a -- it's actually a different proposal, which is just a reduction that links to the PPV rates. And I think it applies to the managed care organizations, with a target. I think it's a little bit different than the previous year's proposal, but still getting back to the point where what we're trying to do is to try to create incentives within the delivery system to reduce avoidable hospital use.

And overall, we've seen those results. We think there's more that could be done. But we're just trying to align our payment policies with the goals of the DSRIP program.

ASSEMBLYMAN RAIA: But how do you force a hospital to tell somebody not to show up in the emergency room?

DIRECTOR HELGERSON: I think there's a lot that hospitals can do, and we've got some very tangible examples of it being done, where the hospital, in collaboration with others in the community, can really do a deep-dive analysis to understand why patients are there. Many reasons they're there is because of needs that are outside of the healthcare space, they have a social determinative health need.

But the problem is is that right now that within the fee-for-service system the hospital has no financial incentive to explore ways, in partnership with other providers, to meet those core needs. And so the people cycle through the emergency room month after month, getting more and more services, when there are other things that can be done to redirect them to better points of care. And we've had some tremendous results already in communities all across the

state.

COMMISSIONER ZUCKER: I think also on that is they end up in the emergency room because they don't know where else to go. And if there are more ambulatory care services available and more clinics available -- and that's where we're working as we do some of the transformation. We have the whole Vital Brooklyn project, which you may be aware of, we're looking at that. And we're looking at it across the state as well. And then people will not show up in the ER because there will be another place for the urgent care that they need.

ASSEMBLYMAN RAIA: Okay. Just a quick comment. Expansion of telemedicine, good. But it would be nice if you could make it uniform amongst all the different state agencies that use it, OASAS -- you know what I'm getting at.

DIRECTOR HELGERSON: Yup.

ASSEMBLYMAN RAIA: Very quickly, what are the Medicaid managed and network adequacy standards? And then what are the access

standards for pharmacies?

DIRECTOR HELGERSON: So each class of providers has a specific set of requirements that are in the contract, basically that managed care organizations must meet in order to have what's deemed an adequate network. If they do not have an adequate network, they're not allowed to enroll people in a particular county. So there's specific standards, and I'd be happy to get to you what those standards are by provider type.

ASSEMBLYMAN RAIA: That would be great.

On the plan benefit side, I'm a little concerned that we're looking at reducing nonprofit plan reserves to minimum levels. How are you going to force them to do that? Operate at a loss or --

DIRECTOR HELGERSON: Right. So happy to have an opportunity to answer that question.

So the concern that we have is is that, particularly in the case of plans for whom a disproportionate share of their

business is Medicaid, where the government in essence is the funder, if especially in difficult budgetary times they're sitting on excess reserves, our question is why. Are we in essence paying rates or have we historically paid rates to them that are higher than appropriate?

And so the concern is -- and we've raised this issue with plans in the past, and this just gives us a little bit clearer direction in terms of our ability to potentially, on a prospective basis, bring down the reimbursement rates to basically capture back some of that excess reserve. We've heard some concerns from plans that perhaps that they may have some of those monies that they could use for good purposes -- investments they could make to improve patient care -- so we'd be more than willing to listen to those proposals.

But it's just -- the question is do you want taxpayer money sitting on the sideline in some insurance company's bank account when we're facing other tough

budgetary decisions.

ASSEMBLYMAN RAIA: All right. And along that same line, then, as far as taxpayer money, the 14 percent tax on the plan earnings, it's my understanding that particularly upstate you have a lot of not-for-profit plans that work with for-profit plans. And then it's my understanding as well in our Medicaid we have for-profit plans that help distribute --

DIRECTOR HELGERSON: Yup.

ASSEMBLYMAN RAIA: So how do you square that circle?

DIRECTOR HELGERSON: So what I would say is thanks to the largesses of the United States Congress, the for-profit health insurance industry in the United States is going to see a significant improvement in their financial position. It's very clear that their tax rate burden --

ASSEMBLYMAN RAIA: But shouldn't we use that to lower rates instead of taxing them?

DIRECTOR HELGERSON: Well, so what

we're saying is that in difficult budgetary times, an industry that's seeing a windfall, basically, improvement in its financial position, those dollars are going to exit the State of New York and go back to Minnetonka or the other communities that are the home to these for-profit insurers outside of the State of New York.

Our hope with this proposal is to capture some of those funds. And as you know, the proposal in essence is to stick those funds into this reserve account, which in essence will then help support us preventing really negative things happening to Medicaid members or other New Yorkers as a result of other actions the federal government may take.

So I think it's a fair proposal to fund, you know, efforts to, you know, make sure that we don't have really bad unintended consequences from other federal actions.

ASSEMBLYMAN RAIA: All right, thanks. I have a few others, but I'll send them to you in writing. I appreciate your time

today.

SENATOR HANNON: Senator Serino.

SENATOR SERINO: Thank you, Chairman.

Thank you again, Commissioner.

As you know, I chair the Aging Committee and I have an elder abuse hotline bill that was put in that was vetoed this last year. And I understand that you're the Commissioner of Health and a lot of these conversations are with SOFA or OCFS, but this is something that impacts the health, physical, mental and financial health of seniors -- and, as you are aware, can impact the life expectancy of a person who has been a victim. And it is the most underreported crime in the country.

And I know I had discrepancies on the dollar amount, too. I was told $5 million and then when I got the call to say that my bill was going to be vetoed, it was up to $14 million.

But I just feel like -- as most of us do, I think, today as our conversation has been with our seniors -- you know, they've

lived their lives here. And then what did we do? It's like a slap in the face. We don't -- they're the most vulnerable. We don't do things to help them. And I always go back to my district, because I say I'm the voice. I feel like Albany lives in a bubble, and I'm asking you to be the voice for our seniors. And for our, as I spoke about earlier, our Lyme patients as well.

COMMISSIONER ZUCKER: I promise to be a voice of the seniors. And I've worked very hard in the department to address this issue, not just the issue you brought up about elder abuse, but just across the board, all the issues of seniors. And this is where we're talking about -- whether it's the Alzheimer's issue, whether it's how to keep people at home, home aides, whether it's issues of seniors not having to run across the state or run, you know, many miles to a health provider.

One of the other things that we are looking at is just about seniors who end up in emergency rooms and how do you provide

care for seniors in ERs so that they -- that's a challenging environment, particularly for one who is elderly, may have some cognitive issues, and they're sitting there in an environment which is extremely stimulating, and it may not be the best environment for them. How do you make emergency rooms more user-friendly for those who are elderly? How do you make hospitals more user-friendly for those who are elderly?

And we're addressing this, and I've spoken to both the Greater New York Hospital Association and others about this and some of the things that we could do for them. And I do have a meeting soon about some of these issues about emergency rooms as well.

SENATOR SERINO: It's all scary. And Senator Krueger, your comments about what's going on in Japan, oh, my God, that is -- it's horrible.

And I feel like our seniors really, here, feel like they're disenfranchised. And I know that it's kind of like a fragmented system, because we have APSs and OCFS, SOFA

is responsible for senior issues, and DOH is in charge of reporting in long-term-care facilities. So I'm just asking that maybe we can all work together --

COMMISSIONER ZUCKER: Sure. So the Governor has asked us to look at health across all policies, and we are. And this applies not just to those who are younger but also to seniors. The state has become the -- as I mentioned in my testimony, the first age-friendly state. There are certain criteria in the World Health Organization and others that give us that designation.

And we will move forward to make sure that New York is at the forefront of taking care of those who are elderly. And I think that there are many other opportunities of things we could do, both working -- not just with the senior population, but also partnering with younger generations, so maybe having a generation who are in college or graduate school work with those who are seniors to be able to help them in those years.

SENATOR SERINO: Okay. Thank you, Commissioner.

CHAIRWOMAN WEINSTEIN: Assemblywoman Bichotte.

ASSEMBLYWOMAN BICHOTTE: Yes, Commissioner, I just wanted to clarify, going back to the CRNA definition of oversight, do you agree that oversight is very different from supervision?

COMMISSIONER ZUCKER: Well, there is a physician's supervision that Article 28 facilities have to have.

I think that -- you know, this issue with CRNAs, let me sort of take this from the standpoint of one who has practiced, as I was saying before, anesthesiology. The most important thing is the safety of the patients. And I would trust that the hospitals or any health system that is providing care will make sure that is the most important thing that they do. And if there needs to be appropriate triage of which patients will be cared for by whom, I would hope that that is what they would do.

I know from my experience that, like I said, there are excellent CRNAs. I've worked with them, and I recognize what they can do and what they can provide. I also recognize clearly what anesthesiologists bring to the table and other physicians bring to the table.

ASSEMBLYWOMAN BICHOTTE: Okay. So with that said, again, because patient care is of the utmost importance, you know, if we leave it up to hospitals, hospitals can make decisions of finding ways to cut costs and also compromising especially communities of color having access to real quality care.

And when we talk about saving money, it really -- it's not really saving money. I mean, it's liability and risk that we have to take into place.

And, you know, with you, I certainly support and actually honor the work that CRNAs do. But just generally speaking, with certain specialties, we need to be very careful.

COMMISSIONER ZUCKER: I understand.

ASSEMBLYWOMAN BICHOTTE: We have to be very careful. So not all institutions will require this supervision, and that's why we should continue to codify with the state that certain specialties need supervision, need licensed supervision, and that's what we're making sure.

So, you know, we haven't seen the word "supervise," we've seen "collaborative," which -- we don't want any fighting going on during the operating room or anything like that. We want to make sure that the patient's safety is at the forefront. So thank you for that.

And secondly, I just wanted to just make a comment about safe staffing. Every year in the Assembly we pass the legislation. We want to make sure that healthcare workers -- in particular nurses, but all healthcare workers, for that matter -- the healthcare-worker-to-patient ratio needs to be adequate.

So even though it wasn't mentioned in the Executive Budget, I want to put it out

there that we're going to continue to fight and we're going to push to make sure that patients get adequate care and there are sufficient healthcare workers that can attend to their needs.

COMMISSIONER ZUCKER: I hear you.

CHAIRWOMAN WEINSTEIN: Senator Hannon.

SENATOR HANNON: You'll be happy to know I think I'm the last one for questions. But appreciate your patience. One of the these days we're going to get --

DIRECTOR HELGERSON: There's something wrong with the mic.

COMMISSIONER ZUCKER: The microphone's off, I think.

SENATOR HANNON: -- microphones that work. It's on. The light's on. And unfortunately, the commissioner can hear me.

I basically have a series of just comments, a couple of things. One comment, I want to go on record about VBP QIP. I simply disagree with the process. I don't think it has long-term sustainability. And I think at some point the feds are going to throw the

red flag on you. Let it be there.

Transportation. I think from the number of people who have made comments today by the Senate, that is a continuing concern. And by the way, the comments were made by upstaters; I know it's a comment that will go for the city or for the island.

And if we talk about social determinants of health, transportation is as much a social determinant as anything else.

And if we can give housing as part of the Brooklyn program as a social determinant and take the money for the housing from non-health department, then I can't see why we can't focus on this. I know there was a need for a statewide master control of it, but still the complaints show that there's a lot of problems in between.

I congratulate you on the introduction of a new acronym, the RMI. I didn't realize that the Regulatory Modernization Initiative had become an acronym. I hope we don't lose the force of it, because some of the things they're doing are excellent and overdue.

The -- oh, a very small point, the UAS, Uniform Assessment System, was put in to be a care tool. And unfortunately, it's been captured by Mr. Helgerson's Medicaid budget keepers as a fiscal tool. And I think we'll lose sight of what we needed it for. It was a good reform for care and a measurement of care. And to make it just a fiscal tool I think means it's going to be subject to the susceptibility of humans to game it, and that I think is a real big problem.

Bigger picture, you've several times made mention of "we wish Mujica were here." I'm sure after these lengthy interrogations, he'll never come. But think of where the bigger picture is for healthcare we're going, and it's the bigger numbers.

The 2 percent opioid tax -- now, presume you can get over the hurdle because we're still looking to what happens in the money for the pharmaceutical drug cap from last year, because that hasn't shown up -- but where that money goes and how it's used.

The 14 percent that's supposed to be

taken from the windfall for the insurance companies, where that goes and how it's going to be used.

The $500 million or whatever, $250 million this year, from Centene for Fidelis, where is it going, what's going to be used?

You made mention, Mr. Helgerson, of a contribution to the General Fund from the global cap. Where is that going, and how is it going to be used?

And then simply the VBP QIP, which I mentioned before, that's going to fund part of the Essential Plan. But why? Because some parts of the Essential Plan are getting a boost from the increase in the premiums from the federal government.

So these big-picture things need to be addressed. And I don't see how you can move forward with all of the rest of the health budget unless you resolve this. What's going to be done with this money? What's it going to be used for? What's the accountability for it, and how do we explain this to the

residents of New York State?

And so at the end I think your comment, Mr. Helgerson, the aging population is fine, but you have no idea what the intense bureaucracy of the Health Department does when it puts rules and regulations to implement all of this long-term care.

We daily hear squawks from everybody who's trying to do care -- whether it's a union, whether it's a provider -- how they have to meet those rules and regulations. I think we are being counterproductive on where we go.

And then finally, two things, Commissioner. You made just brief mention of the Brooklyn, a huge positive initiative in this administration with just a focus of different powers of the budget and state powers to create healthcare providers. I think it's something that should be really part of your initial testimony.

And then lastly, you had mentioned once a thing called candida --

COMMISSIONER ZUCKER: Yes. C. Auris,

yes.

SENATOR HANNON: -- a new bug that's going to be in all the hospitals. I read this morning it went from 16 cases in the United States, in 12 months it's gone to 200, and there's no drug or cure for it.

So you thought your administration has been through lots of different -- Ebola and Zika and all that. You're the one who's already been on the case and given lectures about candida. So congratulations. Have a good 12 months.

COMMISSIONER ZUCKER: Thank you. See you in 12 months.

(Laughter.)

SENATOR HANNON: Thank you very much for your patience. Appreciate it.

COMMISSIONER ZUCKER: Thank you.

CHAIRWOMAN WEINSTEIN: Thank you. Hopefully we didn't keep you too long.

(Laughter.)

CHAIRWOMAN WEINSTEIN: So we -- yes, that's it. And I know there's some follow-up questions that members are looking forward to

receiving answers to. Thank you.

Next we're going to hear from the New York State Department of Financial Services, Maria T. Vullo, superintendent.

(Discussion off the record.)

CHAIRWOMAN WEINSTEIN: As soon as the room clears, we'll be able to start.

Can the people who are leaving please leave quietly? Or others take your seats after having stretched your legs.

Superintendent?

SUPERINTENDENT VULLO: Thank you.

Good afternoon, Chairpersons Young and Weinstein, 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 testify before you today.

I've submitted a written testimony but will just briefly summarize that testimony. And I'm happy to provide an update and answer your questions regarding my agency, the Department of Financial Services' efforts to strengthen New York's healthcare market and

preserve New Yorkers' access to vital healthcare coverage.

Over this past year, at a time when our right to vital healthcare coverage has been under attack in Washington, my team and I have spent a substantial amount of time focusing on ensuring the continued strength of New York's commercial health insurance market, which DFS regulates. While ensuring the integrity of the market, we have also addressed many consumer protections in healthcare, including the opioid epidemic, women's reproductive rights, early intervention for infants and toddlers with disabilities, and HIV prevention.

New York has been steadfast in vigorously supporting the Affordable Care Act as it continues to make more affordable, quality health insurance coverage available to New Yorkers. Due to our efforts, New York's healthcare market continues to remain robust, with 14 issuers offering individual coverage, 20 issuers offering small group coverage, and consumers in every

county having a choice of coverage. The New York State of Health also maintained a longer enrollment period through January 31, 2018, despite the much shorter federal enrollment period, and that paid off. More New Yorkers enrolled in plans than ever before this year.

Yet we are very concerned that healthcare costs for the most vulnerable New Yorkers may rise due to the continued actions of the federal government, including the continued failure to fund the Cost Sharing Reduction subsidies. I submitted a declaration in support of the New York Attorney General's lawsuit seeking to compel payment of those subsidies, and we continue to advocate for their payment.

In addition, in light of the federal government's efforts to roll back access to quality affordable healthcare, I traveled across the state to moderate healthcare panels and educate the public about the dangers of the efforts on the federal level. Such efforts continue, as the federal

government has indicated that it may seek to further destabilize state healthcare markets by seeking to expand the definition of "association health plans" and allow sales across state lines, two efforts that would permit the cherry-picking of risk and a race to the bottom in consumer protections, further causing increased rates and reduced healthcare coverage.

Last year DFS promulgated new emergency regulations providing that regardless of any federal changes, health insurance providers in New York would not discriminate against persons with preexisting conditions or based on age or gender, in addition to safeguarding the l0 categories of essential health benefits.

We also protected women's healthcare by issuing a regulation and guidance requiring that insurance companies provide coverage for contraceptive drugs and devices and follow-up care at no cost-sharing, including the dispensing of a 12-month supply of contraceptives. This session, the

Governor will advance a program bill, the Comprehensive Contraceptive Coverage Act, to codify access to contraception, including emergency contraception. These are important protections for women's health.

In addition, DFS promulgated a regulation to ensure that health insurers cover medically necessary abortions, without cost-sharing. We also issued guidance to ensure coverage for infertility treatment regardless of an individual’s sexual orientation, marital status or gender identity, and coverage of 3D mammograms, which was ultimately codified in recent legislation signed by the Governor. And as part of the New York State Council on Women and Girls, DFS will conduct a study regarding appropriate insurance coverage for in vitro fertilization and fertility preservation.

As you know, New York's best-in-the-nation Paid Family Leave program was launched last month. As New York's insurance regulator, DFS is proud to have worked with our colleagues at other state

agencies to provide the framework to ensure the successful implementation of this program, which is a disability insurance program that provides important protections to New York workers and families.

Looking forward, DFS is proud to support the Governor's Executive Budget initiatives. I will discuss two budget items.

First, as you know, the recent federal tax bill reduced the federal corporate tax rate from 35 percent to 21 percent. As health insurance rates were set within the context of a higher tax regime, we believe that the unexpected gain received by for-profit insurers writing health insurance coverage in New York should be captured by the state to fund healthcare programs that are being drastically reduced by the federal government.

The Governor is proposing a tax law amendment that will impose a 14 percent fee on for-profit insurers on net underwriting gain from health insurance products, so that

those funds can be reinvested in vital healthcare services for New Yorkers.

Second, in an effort to protect and support some of our most vulnerable New Yorkers, we must safeguard the services provided young children through the Early Intervention Program. DFS has already taken action to ensure that insurers cover Early Intervention services for infants and toddlers with disabilities, reminding insurers that they must provide a municipality or its designees and service coordinators with information on health insurance benefits for children participating in the Early Intervention Program upon receipt of a request for such information. This information is essential to enable municipalities to administer the program cost-effectively so that covered children have full access to services.

The Governor's Budget also proposes to increase penalties to support DFS's efforts to ensure that, first, insurers pay claims for all covered Early Intervention services;

and second, insurers do not deny claims because neither the provider nor the insured will challenge denials given the guaranteed coverage provided through the state's program.

Even beyond the Early Intervention Program, we firmly believe that the willful failure to pay claims and the willful making of false statements to DFS are the two most destructive violations of the insurance law that an insurer or agent can commit, warranting appropriate fines.

DFS is also honored to support additional State of the State initiatives of the Governor, including strengthening New York's external appeals program and improving the transparency of healthcare costs. New York has one of the most robust external appeals programs to assist New Yorkers who are wrongfully denied healthcare coverage. We receive more than 10,000 external appeals each year.

Under this new initiative, DFS will create a new searchable database of external

appeal decisions, with personal information redacted, so that consumers, providers and insurers can easily access external appeal decisions.

We are also working to promote greater price transparency in the healthcare market. We are assessing requirements that health plans provide their members with additional information, such as cost-estimator tools and quality ratings about healthcare providers in their network, so that consumers can make more intelligent decisions regarding their choice of provider.

DFS, in partnership with the Department of Health, will also provide specific recommendations to simplify medical bills so that consumers can more readily understand them.

Lastly, DFS is supporting the Governor's efforts to reduce the costs of local governments. The Governor has directed DFS to publish guidance and provide technical assistance to local governments in order to ease the process of creating health

consortia. We have already been working with a number of municipalities, including Otsego, Saratoga and Suffolk counties. And we just approved a new muni co-op in Rochester that started last month.

My team at DFS is working hard every day to build on our successes and make New York's financial services industries work even better for both industry and consumers. Thank you for the opportunity to outline some of the work that DFS is doing and our role in the Governor's 2018-2019 priorities relating to healthcare. I look forward to your questions.

SENATOR HANNON: Senator Seward.

SENATOR SEWARD: Thank you.

And thank you to you, Superintendent Vullo, for being here today to testify.

I know that you share my belief that it's both important and possible to strike that right balance between protecting consumers as well as enhancing the financial services industry of our state, which is so critical to our state in terms of its impact

in a positive way on our economy and also, of course, providing much needed services to the people of the State of New York.

I wanted to zero in on Section 16 of Part O -- you know, the increased fines portion. Back in 2011, the fines for insurers were increased, you know, from $500 up to the current $1,000 level. And of course it strikes me that the department has plenty of other hammers to use to beat back bad actions on the part of insurers of our state.

So my question is, why does DFS seek to increase the fines by a thousand percent, up to $10,000? Is the fine increase intended as a revenue raiser for the state? And also, what are the estimated -- if this proposal were to be included in the budget, what would be the estimated projected revenues from this action?

SUPERINTENDENT VULLO: Thank you for that question, Senator Seward. And I do agree with you on striking an appropriate balance between promoting industry growth and

protecting consumers, and I think that balance is certainly something that is doable.

With respect to the fine provision, the fine provision addresses two issues. One is the willful failure to pay claims, and the second is the submission of a false statement to the Department of Financial Services.

If someone submits a false statement, say a false financial statement, under current law I can fine them $1,000 because it's $1,000 per violation, and that's one violation. That doesn't deter bad actors as we need to deter bad actors from doing that. So this is not an effort to increase fines overall for any type of activities, but for the willful failure to pay claims, which I think is something that, you know -- and talking about the health issues, that's something that I think is a deterrent -- and secondly, the willful submission of false statements.

So it doesn't cover, you know, other things where we might be able to levy fines.

So that's why the proposal is in here. We talk about it in the context of Early Intervention, the Early Intervention programs, but we do seek it more broadly than that. But that's the idea.

I have not estimated it, nor is the proposal there for purposes of revenue generation, although of course it would. But I actually prefer the deterrent impact of fines so that we don't have false statements, for example, or the failure to pay claims.

SENATOR SEWARD: Well, I would agree that failure to pay claims and making false statement or submitting false information to the department are serious offenses. Could you describe what other -- other than imposing a fine, what other actions under those circumstances you have at your disposal as a department, against those that either do not pay claims or make false statements?

SUPERINTENDENT VULLO: I can put a company in liquidation or rehabilitation if the management of the company is not acting appropriately. That is a last resort that

often hurts the policyholders and -- not in the healthcare area, but in other areas -- impacts the guaranty fund, so it's not an option that we prefer.

We have seen circumstances of recalcitrant management. These are not -- these are the rare situations. This is not the overall situation. And we've had circumstances of the willful failure to pay claims and, you know, we do have certain remedies that we can -- but imposing fines is something that might get someone to act.

And I don't think that putting a company in rehabilitation is the -- I mean, I will say we had proposed an administrative supervision bill last year. I would still urge that bill, because I think that would give us additional powers for, you know, companies and in particular company management that's not doing the right thing for the solvency of the company or for the consumers and the policyholders of the company. And that's the genesis of these proposals.

SENATOR SEWARD: Why were these provisions included in the Early Intervention part of the health budget? I mean, these apply to all forms of insurance, am I correct in saying that?

SUPERINTENDENT VULLO: I can't speak to why they were put in a particular part of the budget. I don't put it together.

SENATOR SEWARD: Okay. Understood.

What is the breakdown of fine revenue? I know you can't -- you said you can't project what the future would be. But in terms of the past -- let's say the past couple of years, as an example -- can you provide us data, either today or in the near future, in terms of what revenues have been collected by DFS from fines, based on the various sectors of insurance, whether it be P&C, health, life, and so on?

SUPERINTENDENT VULLO: I don't have that information in my head, but we can certainly provide it, you know, on the insurance side, if that's what you're asking.

SENATOR SEWARD: Right. Yeah, I would

like that.

SUPERINTENDENT VULLO: The fines on the banking side are much larger than they are on the insurance side.

SENATOR SEWARD: Shifting gears on another -- a couple of other issues. You know, as part of New York State's effort to get ready for the Affordable Care Act back in the '13-'14 state budget, we amended our law here in terms of the definition of a small group, from -- we went from 51 up to 100, to conform with the ACA.

And of course in 2015, I believe, the Congress -- and then President Obama signed it into law -- they passed it and the president signed it into law, giving states flexibility in terms of defining the small group as having -- back down to the 1 to 50. Since that time, nearly every state has moved forward and gone back to the 1 to 50 in terms of definition of small group.

We here in New York have been grandfathering those in the 51-to-100-employee category, grandfathering

them in so that they can continue to have self-insurance with a stop-loss provision and coverage, as long as they had that in effect by June 1 of 2015, back when we did the legislation.

Now, also in that 2015 law, we required DFS to contract with an independent entity to study the effect of the sale of stop-loss -- you know, the catastrophic and reinsurance coverage on the small group market. Now, this report is due to the Legislature on or before March 1, 2018. This report is due within a month. And can you give us a status report? Will we be receiving this report by March 1? And can you share any details of what we might expect to see in that report?

SUPERINTENDENT VULLO: Senator, that report is in process and it has not yet reached my desk for review or to talk with the team about it. But, you know, certainly I'm aware that the report is being prepared. And I think it's better not for me to foreshadow something that hasn't yet reached

my desk in terms of recommendations from the staff.

I would say, though, that on the small group 50 versus 100 question, I firmly believe that it's better to keep it at 100 because that protects the risk pool, to have more people in it, than to reduce the size of the group.

But in terms of, you know, stop-loss insurance and the grandfathering, those are obviously issues that were determined several years ago, and we're looking at those in terms of really our overall concern about, you know, the markets and maintaining at least a good balance of healthy and unhealthy comprehensive healthcare, and keeping premiums as low as we can. So those are the general subjects.

But in terms of recommendations, we haven't gotten to that point yet.

SENATOR SEWARD: Do you think we'll receive that by March 1?

SUPERINTENDENT VULLO: I certainly like to keep deadlines.

SENATOR SEWARD: Okay. Well, because we do need to make, you know, some policy decisions, you know, in statute going forward.

SUPERINTENDENT VULLO: I've noted it. Thank you.

SENATOR SEWARD: And you indicated your personal preference to keep small group at a hundred employees versus, you know, the 1 to 50. Did I just hear you say that?

SUPERINTENDENT VULLO: Well, I wouldn't call it a personal preference. I think the data certainly shows that, you know, larger groups would have more of a balance of healthy versus unhealthy individuals. And the more people that you keep in a particular market, the more likely you are to have a better risk pool.

So if you were to remove those employers who are, you know, 51 to 100 out of the small-group market, you're reducing the overall number of people in that market, and that creates an issue for the risk pool. Which would, you know, create issues with

respect to healthcare costs and premiums.

And I think that's just -- I think that's factually undisputed in terms of the smaller the risk pool. You see that in the large-group markets. So the large employers in the large-group market have a much better risk pool than in the small-group market. So -- and of course they also use a different kind of a rating. They use experience rating versus -- most of them -- versus community rating. And community rating is what we as a state have control over.

So again, if you removed those employers from the small-group market, it would be potentially removing them from rate review, and I don't think that that's a good idea to maintain as low as possible premiums that we can for New Yorkers.

SENATOR SEWARD: Yeah, just -- not to belabor the point, just a couple of reactions to your statement.

Just about every other state in the union has gone back down to the 50 under the federal flexibility that had been provided to

the states. I'm not sure what's different in those other states versus New York, but they're able to do it.

Plus I wish I had brought the stack of letters from not-for-profit employers, school districts, libraries, as well as others, of entities in that 51-to-100 that had been grandfathered to continue stop-loss and the flexibility that all that provides, letters that would say that's the only way they can afford to provide coverage, you know, for their employees.

SUPERINTENDENT VULLO: I'm very familiar with the issue of the nonprofits. And in fact we're looking at that issue statewide as to whether -- and it's one of the Governor's initiatives -- as to whether to make available the state plan, New York SHIP, to nonprofits. That's something that is undergoing.

In terms of other states, I don't have here the list of states that have whatever particular small group, but I will say -- and we're not the only state in this position.

But I will say that we have more companies in our market than most other states do, and our premium increases, while they were not as low as I would like them to be, were lower than what many other states did. And there are a lot of other states that have much more troubled and destabilized markets than New York. So I think, you know, New York should be commended for all of the work that it's done since the Affordable Care Act to have as good of a market as possible.

SENATOR SEWARD: And I'm over my time, but I had one more question.

SUPERINTENDENT VULLO: Sure. Of course.

SENATOR SEWARD: And I'll try to keep my question short.

This has to do -- although this is a big issue. You know, as you cited in your testimony under the federal government changes under their Tax Cuts and Jobs Act of 2017, which does provide a corporate tax cut to the for-profit health insurers right here in New York, approximately a 14 percent

reduction.

SUPERINTENDENT VULLO: Mm-hmm.

SENATOR SEWARD: The question is -- some have called this a windfall. The question is, what is the appropriate use of these funds? Obviously the Governor's proposal calls for substituting a state tax for the reduction in the federal tax.

Absent the Governor's proposal, this increased revenue stream on the part of these health insurers, with prior approval, limits on profits, the medical loss ratio provisions, the rebates that are required, all of those things -- absent the Governor's proposal on taxing this, shouldn't that windfall go back to premium payers?

SUPERINTENDENT VULLO: So we believe that this 14 percent of a tax cut was something that was, you know, unaccounted for, unexpected, and is a windfall. In New York we obviously have vulnerable populations in need of healthcare, and we have budget issues with respect to those vulnerable populations and healthcare, along

the federal government cuts of vital healthcare services.

So given that this 14 percent was unaccounted-for, we think that what's appropriate is for that money to go into a fund -- that is in the HCRA fund, that's how the statute works -- in order to address the federal budget cuts and our healthcare needs in New York.

With respect to the second part of your question, Senator, it's actually very unclear how to address the reduction of the federal tax corporate rate in the MLR ratio. Because if you included that in, you know, the ratio, that could, in years, because they're paying taxes, it would actually increase the administrative expenses, and that would cause the increase of rates.

So it's not a given that you could just take that, because this is the corporate-level tax. When we look at rate review, we look at business units. So we look at the individual rates and you look at it as a business rate, you look at the small

group and you look at that as a business unit. It's not the corporate income tax of the company that's usually the holding company at the top. So we actually don't include a consideration of federal income tax in rate review, because if we did, that would only increase the administrative expenses, which are 18 percent, and therefore put pressure on the MLR and cause us to increase rates in years where there's taxes that are paid to the federal government.

So actually I think the way that this bill is proposed is the best way to capture it and to get the money to the vulnerable New Yorkers that need it in our state budget. If that helps.

SENATOR SEWARD: I have a number of other questions, but I'm going to defer.

CHAIRWOMAN WEINSTEIN: Thank you.

Assemblyman Cahill, chair of the Assembly Insurance Committee.

ASSEMBLYMAN CAHILL: Thank you, Madam Chair.

And thank you, Superintendent, for

being here today.

I'm going to change the order of the questions that I had based on a few things that you said in response to my colleague and my good friend Jim Seward. I'm going to start with the question about the large group and the small group.

I don't have an exact quote of what you said, but words to the effect of data certainly shows that larger groups would have a balance of healthy and unhealthy people in that group, and keeping them out of the other groups would have a negative effect on those other groups. Is that a fair summation of what you just said?

SUPERINTENDENT VULLO: What I'm saying, Assemblyman, is that when you look at the risk pool, the more people that you have in the pool, the more likely you are to balance the risk and lower premiums. I mean, that's the concept of insurance, right? So the larger the pool of people --

ASSEMBLYMAN CAHILL: So that's a different answer than you gave before.

You're saying the general concept is that, not the data. Because that's what caught my ear, the data. And my concern about that is that's exactly what we asked you and others to study, and you indicated to Senator Seward that that study has not come across your desk, yet you're citing to the data.

So I'm a little confused. Do you have the data or don't you have the data on that?

SUPERINTENDENT VULLO: There's national data on this issue. I can't cite to you the data here specifically. But one of the -- you know, the Congressional Budget Office, when it was looking at changes to the Affordable Care Act, relies heavily on this type of analysis, where the whole concept of the ACA is to expand the risk pool to bring down premiums.

When you look at the data with respect to association health plans, those health plans pull groups out of a risk pool into their own risk pool, and that results in the increase of premiums, ordinarily, in that smaller pool.

When you look at the individual market, before the Affordable Care Act, our individual market in New York was very, very small and premiums were very high. We now have about 300,000 people. It's improved the risk pool. It's just the more people that you have in the pool --

ASSEMBLYMAN CAHILL: Let me clear --

SUPERINTENDENT VULLO: -- and there's data that points to that --

ASSEMBLYMAN CAHILL: If I can interrupt you for a minute. I understand the concept. But you specifically cited to data, and that's specifically what our statute last year, as part of the budget, said that had to be done to -- the study that will be completed by March 1st, so that we can make a decision before these individual plans have to decide whether they have to reconfigure how they offer healthcare.

And if you're saying these are the concepts, that's a very different statement than "This is what the data shows." Because we've asked you to look at the data, you've

testified the data is not available. And if you're relying on the concepts, great, I support your idea there. But I just was asking about whether the data is actually available that you testified to.

SUPERINTENDENT VULLO: As I said, Assemblyman, we will be doing the report. There is data available. I don't have the specific cite and verse of the data. But national data demonstrates the importance of large risk pools to bring down premiums in many, many different areas. And in fact it's the fundamental premise of the Affordable Care Act.

ASSEMBLYMAN CAHILL: So moving on to the health tax that the Governor has proposed, the 14 percent tax on healthcare, why has healthcare been singled out as an industry, and health insurance in particular been singled out as an industry, when the corporate tax breaks that were handed out in Washington applied to all industries?

SUPERINTENDENT VULLO: I can only speak to the particular proposal that's in

the budget. And given that we have drastic cuts that have already happened and that are being anticipated from the federal government in healthcare, that this 14 percent windfall should go to the fund, the HCRA fund, in order to help fund those services.

I think that that's really what the proposition is. Whether or not the Legislature and the Executive wish to expand that more broadly, I think that's up to you. But I can only speak to the particular proposal, and the reasoning behind that specifically tied to what's happened with the federal government reductions in healthcare funding, as well as the fact that the companies, as they set their rates, did not account for this windfall that they're now receiving.

ASSEMBLYMAN CAHILL: You indicated that the profit of the parent corporation does not enter into the determination of the rate that a company is allowed to charge for their health insurance. Is there anything else that's being done by DFS to assure that

none of this tax gets passed through to the consumer?

SUPERINTENDENT VULLO: Assemblyman, what I said was that income taxes are not taken into account in our rate review, and that income taxes are paid by the corporate entity, not on a division basis. A lot of these companies have consolidated tax returns.

But we have our proposal in this budget. We believe that that's an appropriate way to be able to have funding for the most vulnerable New Yorkers in the HCRA funding program. And, you know, if that doesn't pass, then we'll look at other options if there are any options available.

ASSEMBLYMAN CAHILL: Okay. So I didn't hear an answer to the question, but I'll move on anyway.

Long-term-care insurance has kind of collapsed nationwide, and it's no different here in New York. There's been a huge problem with long-term-care insurance. What is the department doing to try to rectify

that at this point in time?

SUPERINTENDENT VULLO: So long-term care is obviously a national problem. You know, 20-some-odd years ago the assumptions that were made by the insurance companies writing this were not accurate, at least they turned out not to be when it came to lapse rates. And of course the long low interest rates had a great impact. It's a nationwide problem. We're actually in better shape in New York than we are -- than some of the other states are, or nationally, because we have a lot of New York-only companies that we've regulated and maintained better reserves than some of the other companies nationally have.

We look at these applications and these requests for rate increases very, very carefully. We don't like to grant rate increases, but there have been a number of occasions where we've had to because actuarially there just was a need for it because otherwise either that book of business or the company would be insolvent

without the rate increases.

What we've done to protect consumers as best as possible is, particularly when there are significant rate increases, we've required the companies to offer landing spots, meaning an alternative. So if you don't want to pay the rate increase you could take some kind of a reduction in benefits. Sometimes that's just sort of percentage on the inflation of the healthcare costs.

The other thing that we've done is we've encouraged long-term-care riders on insurance policies. And actually last legislative session there was a bill that was passed and signed by the Governor that fixed the Insurance Law to encourage more of the long-term-care riders to life insurance policies.

That's something going forward, because long-term care as an industry is -- the healthcare costs of it are just very high given life expectancies and improvements in medicine over the past 20-some-odd years. It's obviously a difficult problem, and these

are not easy decisions.

And I'll tell you, I don't like to grant those increases, but they're actuarially justified when we grant them because we need to protect the solvency of either that book of business or the company.

ASSEMBLYMAN CAHILL: Another failure is the Health Republic co-op. I won't ask you to answer that now, but if you could provide us with a status report on what your agency is doing to address the many loose ends that were left when Health Republic went out of business.

But I do want to go to the next one, which is more forward-looking, and that's the Paid Family Leave risk adjustment mechanism. And if you could explain what the department has done on the Paid Family leave risk adjustment mechanism to assure that it too doesn't collapse like long-term-care insurance and like Health Republic did.

SUPERINTENDENT VULLO: Would you like me to address Health Republic? Because I'm happy to give you --

ASSEMBLYMAN CAHILL: No, no, I'm asking -- I said maybe you can do that in writing afterwards. I'm asking about Paid Family Leave risk adjustment.

SUPERINTENDENT VULLO: Okay. So the Paid Family Leave risk adjustment doesn't have anything to do with Health Republic or long-term care --

ASSEMBLYMAN CAHILL: No. No.

SUPERINTENDENT VULLO: So Paid Family Leave is --

ASSEMBLYMAN CAHILL: Actually, that's exactly right. I'd like it not to, which is why I'm asking the question.

We've had failures in both of those -- that one industry, and we had failure with that one company. They didn't in Vermont, where the regulator prevented them from ever entering into the state. So I'm trying to make sure that we don't have a problem with Paid Family Leave, as families start to rely upon it and premiums are determined and risk adjustments are being made. So I'm asking you about what steps have been taken to

ensure that the risk adjustment mechanism is appropriate, and what steps are taken to be able to modify it should there be an early warning that there's a problem.

SUPERINTENDENT VULLO: The risk adjustment mechanism in Paid family Leave is intended to balance, to the extent that certain insurers -- this is a disability insurance program -- to the extent that certain insurers wind up having greater claims than others.

So in the regulation that we issued with respect to Paid Family Leave, we included a risk adjustment mechanism. That mechanism would come into play after the year. So Paid Family Leave just started January 1 of this year. The rate has been set. It's an employee contribution. It's .126 percent of wages, up to a maximum of the average weekly wage across the state. And we did that rate setting, which I came out with in the summer of 2017, based upon actuarial analysis and based upon experience in some other states that have paid family leave.

Obviously it's the first year of the program, and we would hope and expect that the amount that we set is appropriate. But if it's not because there's an imbalance that some carriers happen to have greater claims than others, that's why risk adjustment was there.

I will say that we have 26 carriers that are writing Paid Family Leave. We had an extensive outreach with the carriers in coming up with our rate setting. We hired an outside firm to look at the data on that to arrive at the amount, because we didn't want to charge more than we had to, since these are employee payroll deductions. But, you know, we did our very best with all of that input that we received. But yes, we included a risk adjustment to try to balance it out.

And remember that these are -- Paid Family Leave is part of a disability insurance policy, so the carriers that are writing Paid Family Leave are disability carriers. I also have the ability in the setting of disability rates to adjust to the

extent that we have some issue with perhaps not having or underestimating the amount of claims for Paid Family Leave.

But we used the data that we had, and I think set a system so that certainly the payments have to be made by the carriers.

ASSEMBLYMAN CAHILL: I've run out of time, but I'll come back on the second round.

I do want to point out that if it's being considered a disabilities policy, it probably is going to come under the Governor's 14 percent health tax. And we can talk about whether that has been factored into the rate.

But I'll give back the time to the Senate.

SENATOR HANNON: Senator Savino.

SENATOR SAVINO: Thank you, Senator Hannon.

Good afternoon, Superintendent.

SUPERINTENDENT VULLO: Hi, there.

SENATOR SAVINO: I want to focus on two issues, one of which you mentioned in your testimony.

As you know, you and I have had several conversations about the lack of insurance coverage for in vitro fertilization and cryopreservation, so I was happy to hear the Governor include it in his women and children's proposal. But I'm a little confused, because in your testimony you said a study, that DFS will be conducting a study regarding appropriate insurance coverage for IVF and fertility preservation.

So that's a little different than moving forward with the issue. So what are we studying? Because as we know, if you work for the state -- if you work for my office, work for your office, work for the Governor's office, all of our employees are entitled to coverage for IVF and cryopreservation. So how do we -- what are we studying to see to it that we can expand it to everybody?

SUPERINTENDENT VULLO: We're looking at a number of different things. And certainly the data from the state program is data that we've already obtained. We're looking at it because the populations could

be different, so we're looking at the -- to figure out what the cost of this would be.

And there's a number of other states that actually cover in vitro fertilization as well as the fertility preservation -- although that's less of a cost, we think, than the IVF. We want to look at the various different ways of covering it. Is the state plan the best way?

And there is an underlying question of what we would do and whether it would trigger a state fiscal under the Affordable Care Act, because we want to avoid that, and that's an issue that the federal government could come at us and say that it has to be paid. I certainly want to avoid that.

So rather than us rush with the legislation, we decided to do this. And we've already started this process and gathered the data. And then we want to come up, you know, there's a number of different ways of providing the coverage. You know, interestingly, the way the Empire Plan does it is it makes it -- there's a cap. The

Affordable Care Act, in the commercial market, doesn't actually allow you to do that, so you'd have to do it a different way.

And then there's questions of do you need to have different procedures done prior to IVF, or can you just go straight to IVF. Do we want to do any kind of age limitations or issues in that. So I really want to -- you know, so we're going to look at all of those issues. Be happy to have, you know, conversations and input from everyone on that. But that's the idea.

And fertility preservation is different and probably, from our preliminary information, you know, it's a less costly option. And of course if we do this in the commercial health market, it could raise rates. But we want to actually look at what that would be, because people would say it's very high. I'm not sure it's as high as what people say, so I -- and that's part of the analysis as well.

SENATOR SAVINO: Do you have a sense of what the time frame for this study is, and

the report back? If you don't know the answer, that's fine, but --

SUPERINTENDENT VULLO: Yeah, I don't know. I mean, we're actively working on it. I want to make sure that we get the data. I mean, we were able to get some data, but I wasn't able to get data from some of the other states just yet in terms of their programs and their legislation. And so that's what we're waiting on.

SENATOR SAVINO: We can follow up on that.

SUPERINTENDENT VULLO: Sure.

SENATOR SAVINO: I want to shift to, because I don't have that much time -- I may have to come back again.

As you know, we've worked very hard and your office has been a great help to us with developing a plan to deal with abandoned and zombie properties. And as you know, in 2016 a statewide database was created to track vacant and abandoned properties across the state.

Can you give me a sense on the

progress of the development of the database? Like have localities been cooperative, or banks meeting their duty to update the database? Have any fines or penalties been issued? And, you know, are we seeing other tools that we need to utilize to really crack down on this problem?

SUPERINTENDENT VULLO: Sure. We've -- we have about -- certainly at least 50,000 properties in our registry of these zombie properties. We have developed a robust program for inspections and enforcement.

We spent three or four months traveling the state. We had meetings in every region across the state with the local officials in that region that were very well attended, because the statute very, you know, wisely provides a partnership with the local officials, who also have enforcement authority under the statute.

So we've actually engaged with a number of local officials who are actually using that enforcement authority. And should they actually receive fines, they can bring

it into their local budgets, it doesn't go to the state. So we actually did these programs to educate local officials across the state on the law and created those partnerships.

We have imposed fines ourselves of -- where there's maintenance lapses, where the banks or the servicers have not complied, and we have issued a number of fines and collected a number of fines.

We've developed a program where we have inspectors doing spot checks across the state, and we actually did some of those recently. And we are now gathering data because that could result in more fines as well to the extent -- and we've been public, you know, as much as we can about this, because we need to get the banks and the servicers to comply with the law. And they should all know that we're out there doing spot checks so that they comply with the law, because of the risk to the communities of these properties not being well taken care of.

Of course there's a whole issue of

getting them in the hands of other -- of new homeowners, which we'd love to see. But that requires, you know, contributions from the state budget. That's not within my ability to do. But I think that that's really a fix too, not simply the maintenance and patching up the doors. They're still eyesores.

And we've worked with the OCA and the courts, because they should really move the foreclosure proceedings for these properties, where there's no homeowner there, move those along.

SENATOR SAVINO: I just want to leave you with -- as you know, the database doesn't apply to real estate-owned properties, where there's no mortgage and the bank is in control.

SUPERINTENDENT VULLO: Good point, yes.

SENATOR SAVINO: So we're considering maybe adding them to the program, perhaps through another piece of legislation, because again we need to make sure we capture all of them. These abandoned properties drive down

everyone's property value and, you know, it makes it that much harder for homeowners who live next door to maintain their property.

One of the other problems we're having, and I'll end on this, I'm not sure if other localities are seeing it, but we now have a prevalence of people moving into these abandoned properties. And through the right of that first possession -- it's the most amazing thing. You don't own the house, you don't pay a quarter for this house, you can go to Con Edison with a lease that you bought at Staple's, they'll turn on the electricity, it's your house now. It's insane.

So we need to continue to work on this, and I look forward to doing that with you.

SUPERINTENDENT VULLO: Yeah, thank you. And just -- I mean, you raise a good point, because the statute only applies to homes with mortgages. So we've actually gotten many, many complaints and unfortunately we haven't been able to address them because if it's not a house with a

mortgage on it, it's not subject to the database.

And then you have the registry requirements or the maintenance requirements, and then you could have people who are once servicers and then they basically acquire it themselves or sell it cheap, and then it no longer becomes part of the law. So I think that's an important point.

And the other, you know, when my inspectors go out, if there's a person in the property, we don't go on it, and we wouldn't have the ability to do anything about that. You know, maybe some of the local officials could. But that -- I recognize that concern.

ASSEMBLYMAN CAHILL: Assemblyman Gottfried.

ASSEMBLYMAN GOTTFRIED: Thank you.

One question. Early Intervention. For several years we have been trying to get more than about $15 million out of the non-governmental insurance world for EI, without success. About 60 percent of nongovernmental insurance is self-insured

plans that we can't regulate anyway. So we spend all this effort torturing EI providers by trying to make them jump through hoops to appeal denials, inevitable denials, from health plans.

So my question is, why not simply say to the insurance industry: We're going to tax health insurance as a collective $15 million -- or pick any number -- and then you're off the hook, we don't want you to handle claims for EI services. Just give us our $15 million, you go your way, we'll go ours. Why not do that?

SUPERINTENDENT VULLO: Assemblyman, I don't know if the $15 million is a number that you wanted me to comment on, because I don't have any reason for thinking what the number is.

ASSEMBLYMAN GOTTFRIED: Well, it's the concept.

SUPERINTENDENT VULLO: I think Early Intervention, obviously, we need to provide the services to those infants and toddlers with disabilities.

There is a piece of the pie where the municipalities are paying providers and not always asking for the reimbursement from insurance. But there's also the other side of that coin where insurance policies don't cover all services or don't cover them for the full amount of days or treatments that there are, and there are other issues there.

But it seems to me that pulling that out of the insurance system is pulling just one thing out. You could do that for a number of other things, and I'm not sure that that would be appropriate comprehensive care. And I think, you know, the question really is are we getting all of the reimbursement that is due from the insurance, the commercial insurance, and that's what this effort is trying to get at, is to ensure that they're paying when they're obligated to pay. And if they are obligated and they don't, that's where the fines come in.

ASSEMBLYMAN GOTTFRIED: Well, I would just urge you to think about the idea that we spin an awful lot of wheels trying to get

blood from a stone. Insurance companies spend a lot of money denying claims, because you've got to spend a little money to even deny a claim.

It doesn't -- to me, it doesn't make a whole lot of sense to go through all of those gyrations for $15 million or -- I mean, I don't care if it's 14 or $18 million, it's in that ballpark. Why not just tell the industry as a whole, Write us a check and we're done with you? I just urge you to think about that.

SUPERINTENDENT VULLO: Okay.

SENATOR HANNON: Senator Kaminsky.

SENATOR KAMINSKY: Thank you.

Good afternoon, Superintendent.

SUPERINTENDENT VULLO: Hi, Senator.

SENATOR KAMINSKY: The North Shore and Child and Family Guidance Center recently released a report about access to mental health and addiction treatment called "Project Access." And I really urge you to look at it. It is really a damning statement on the inability for people to find access to

good providers when they've had the courage to come forward and say, I do have an issue with mental health or addiction.

Many of them surveyed -- 650 Long Islanders were surveyed; many had said that they were getting the runaround from their insurance company, that the ability to find a provider was too difficult, some even gave up during the process. And it's just a really tough atmosphere.

I've heard from some clinicians who tell me it's actually better to have Medicaid than commercial insurance when trying to find mental health treatment on Long Island.

So I just -- I know that I've talked with your office before on this, and I certainly do appreciate that. I just wanted to make you aware of this and ask that your department really double down on network adequacy and make sure that there are decent options for people out there looking for treatment.

SUPERINTENDENT VULLO: Thank you, Senator. And thank you for making us aware

of that report. Obviously network adequacy overall is something that we as well as the Department of Health looks at with respect to mental health services in particular. I do think that more needs to be done on that. I mean, the rules do require that there be a provider in each territory, with each of the services that are mandated by law. And we look at that carefully.

I will say that at DFS we're doing more on also price transparency. We're doing an analysis of that so that there will be more information provided by the health insurers to the consumer so that they can access the information.

We're also -- we have a small federal grant that we're using specifically for mental health, and we've added mental health to our market conduct examinations to make sure that insurance companies are providing that parity for mental health. And obviously the adequacy of the network is something -- so it is something we have a collaborative effort with the Office of Mental Hygiene and

the commissioner there. We're working on all of these issues.

But I agree with you, this is something that we need to do more on, and we will.

SENATOR KAMINSKY: Well, thank you. And I think it's worth viewing this also through the lens of the opioid crisis we're all facing.

SUPERINTENDENT VULLO: Of course.

SENATOR KAMINSKY: You know, when someone is unable to get that treatment or they find it too difficult, of course sometimes they will unfortunately seek a different path. And we certainly want to get them the help that they believe they require. So I really appreciate that.

Thank you for your attention to this. I think if you talk to one or two people who have gone through this, you'll see right away that something needs to be done. And I really appreciate your attention, and it's great to see an NYU law grad doing so well. So thank you.

SUPERINTENDENT VULLO: Great. Thanks, Senator.

ASSEMBLYMAN CAHILL: Mr. Raia.

ASSEMBLYMAN RAIA: Thank you very much.

SUPERINTENDENT VULLO: Sure, Assemblyman.

ASSEMBLYMAN RAIA: We touched on it before, but where are we with Health Republic?

SUPERINTENDENT VULLO: Okay. So --

ASSEMBLYMAN RAIA: The condensed version, please.

SUPERINTENDENT VULLO: Sure. The Health Republic liquidation is actually moving apace. We through -- we've transitioned all of the administrative services to the Liquidation Bureau, so we've reduced costs. We've gone through all of the claims, the policy claims -- it was about 600,000 -- and we issued about 188,000 explanation of benefits.

There was about 1100 appeals, because we had a process for appeals. So we issued

the EOBs and then we provided -- this was all under court supervision -- we provided an appeal process, and only 1100-something asked for appeals. We're going through that process now.

I filed a lawsuit in the Court of Federal Claims in September seeking the -- the request is $577 million for risk corridor reinsurance and CSR subsidies. That case is on hold because there recently was an appeal argued in some cases that had preceded us that may decide some of the legal questions there. I would like to continue forward and get, you know, some money back.

We finished the financial statements, and I think we've made a transparent process. You can go on the website and you can find all of this information there, including the financial statements. But I think that's the general -- I mean, obviously there still will be, you know, money that is not there to pay the claims unless we can get the money from the health insurer.

We did collect some money from a

reinsurance policy. We got $1.8 million from there. We're looking at directors and officers to be able to get the D&O policy to bring some money in there. But it's pretty close to concluding. Again, we know now what -- more what the amount of claims are, and it's in the financial statement. I think it's about $211 million, is in my head as to what the claims are.

ASSEMBLYMAN RAIA: Okay, thank you.

I mentioned this before to the gentleman that preceded you; there's a proposal to reduce the nonprofit plan reserves to a minimum level. I get a little concerned when we talk about First Republic, when we talk about how a lot of these plans are on a shoestring or are a flu season away from going bankrupt, maybe. That doesn't concern you, that they have to drain their reserves down to a very limited number?

SUPERINTENDENT VULLO: My understanding, Assemblyman, of that provision, that provision relates to Medicaid nonprofits -- and again, which is not mine.

But my understanding of that provision is that it's where the nonprofit Medicaid Public Health Law entity, HMO, what have you, has excess or surplus reserves. And where that is the case, that excess amount would then reduce the capitation rate that that insurer would get.

But again, that's -- I'm not trying to duck the question, but it's not really my agency's --

ASSEMBLYMAN RAIA: It would be nice to have you all together and go, This is a serious --

SUPERINTENDENT VULLO: Well, that's -- whatever.

ASSEMBLYMAN RAIA: Fair enough.

SUPERINTENDENT VULLO: I'm happy to answer. But that's my understanding of that. And again, it's just the Medicaid capitation rates where there is, you know, excess or surplus reserves.

ASSEMBLYMAN RAIA: Now, Chairman Gottfried touched on the Early Intervention. There's obviously a big expansion proposed in

the Governor's budget. One of the things -- and you touched on the fines, and it kind of went over my head a little bit. But we're actually giving DFS the ability to increase fines from $1,000 to over $10,000, depending on the case.

Is this happening on a regular basis that you need to use such a big hammer on this? Is something like Assemblyman Gottfried recommended a better way to go? What's your opinion on this? Because I think going from a thousand dollars to $10,000 is pretty excessive.

SUPERINTENDENT VULLO: I think the question, Assemblyman, is whether -- you know, what we really want here is that we want where there's coverage under an insurance policy for Early Intervention services, that we save the municipalities and the state budget from that cost if there's a commercial that can be made first.

And we've done a couple of things. Certainly from my agency, you know, we issued guidance very recently saying that the

insurance companies have to provide within 15 days the information requested as to whether or not the family whose child is receiving services has coverage to try to do that, but then to make sure that we get that full coverage without having to go through external appeals and a process which may delay the services or cause the municipality to expend funds, that if you have the higher fine, you may get the actual coverage.

ASSEMBLYMAN RAIA: Has there been talk about reforming the policy as far as, you know, the appeal after appeal after appeal?

SUPERINTENDENT VULLO: Well, I mean, the policies are not necessarily -- the different coverages in insurance policies are not -- we don't have -- we certainly have standard coverage requirements. But the issues of how much is covered, you know, how much in services, what the rates are that would be provided, tend to be determined in the contracts between the insurer and the provider, which we don't have oversight over.

ASSEMBLYMAN RAIA: Then it's not

standardized across the --

SUPERINTENDENT VULLO: Not always, no. Not usually.

ASSEMBLYMAN RAIA: Thank you.

SUPERINTENDENT VULLO: Sure.

SENATOR HANNON: Senator Krueger.

SENATOR KRUEGER: Hi, good afternoon.

(Exchange off the mic.)

SENATOR KRUEGER: So you already answered questions about long-term-care insurance is really not the place for anyone to be looking. My office has been getting any number of complaints recently about -- that people discover that the company they work for is self-insured and that they can't even get answers about what it's supposed to cover, and that when we follow through with your division, you're helpful but you actually don't know anything either.

So help me understand how we have a secondary system for insurance in the State of New York where no one's ever sure what they're covered for and where to go to even find out that information. It just seems to

me to sort of be a little crazy.

SUPERINTENDENT VULLO: It's called ERISA. And it's, you know, federal employee, whatever, retirement insurance -- whatever ERISA stands for. And it has a clear preemption of state law, state regulation in it. So whenever there's a plan that is an employee benefit plan -- and obviously that could be retirement, it could also be healthcare -- and these self-funded plans are governed by ERISA and the Department of Labor, the U.S. Department of Labor, and we don't have any regulation, or could we, of them.

And it does create real issues. Which is one reason why I'm very much against the expansion of association health plans, because that's -- the Department of Labor came out with a proposed rule, this is the U.S. Department of Labor, trying to expand that definition. Because if you expand it too much and you do it in a context where there would be further a risk of preemption, we wouldn't have any oversight over that

additional.

So it's one of those things that is frustrating. And what happens is we often get consumer complaints about things. And even some of the -- you know, the things that we've done, the great work that we've done in New York State with coverage of certain, you know, diseases or treatments or screening doesn't apply to them. And it's frustrating, and it's a problem.

SENATOR KRUEGER: Just quickly, do you have any reason why you'd see a growth in complaints from consumers on ERISA healthcare insurance? Are they all reducing the benefits somehow?

SUPERINTENDENT VULLO: I don't -- I'm not saying that we have received an increase in those complaints, but we do receive complaints, which unfortunately our answer is, you know, when they come to us and then we contact -- because there will be -- there will often be an insurer, but that insurer is acting basically as an administrator, and it's an ERISA plan. So the consumer doesn't

always know, because they're getting something from what they think is an insurance company, and they come to us, and then when we investigate it, we find out it's actually a self-funded plan.

SENATOR KRUEGER: Shifting off of insurance to a proposal in the budget to create a student loan ombudsman within DFS. So can you explain a little bit about how this is going to work? And is it a different proposal than last year?

I mean, there is such an enormous amount of student debt and shenanigans going on to direct students to sign up for things through these debt consultants. So I want us to have a fix, but tell me how we're going to do that.

SUPERINTENDENT VULLO: So this is a multipronged proposal. It includes a proposal that we had last year, and we added to it. You know, student load debt is number two in debt to mortgage. Mortgage is number one, student loan debt is number two.

New York, the average student loan

debt is $32,000, which is almost 10 percent higher than the national average. So we obviously have a lot of student debt in New York.

Obviously the best way to reduce student debt is the Excelsior Scholarship Program, but that's not addressing everyone, and certainly not people that currently have debt. The federal government is not doing what the prior administration was doing. The U.S. Department of Education is shirking its responsibility towards students. The Consumer Financial Protection Bureau, the federal bureau, has been -- has really been defanged in the new administration. And they had a program to license and regulate the student debt servicers. So the states have to fill in the void.

So this proposal, ombudsman is clearly one of the proposals, which is in the Department of Financial Services, in my agency. That will address questions, mediate disputes, educate consumers. But that ombudsman needs the other provisions in

there, which are two pieces of legislation. One is the licensing of student debt servicers. These are the people who are the debt collectors, and they should be licensed just like mortgage loan servicers are licensed, and just like banks are licensed.

And so we would license them. And then you mentioned debt consultants, which is very, very important. We have a piece of legislation that bans inappropriate practices of the debt consultants. You know, these are people that will call you up and say, If you give me, you know, 15 percent up front, I'm going to reduce your overall debt. And they obviously have predatory practices, and so we want to get rid of some of those bad practices. So that's a piece of it too.

And I think it's really all of a package. The ombudsman is not actually legislative, because we can appoint somebody to educate. But the ombudsman only has teeth if we give the department the powers and we do the legislation on the debt consultants and the servicers.

SENATOR KRUEGER: And are those included in the Governor's budget language?

SUPERINTENDENT VULLO: They are. They're I think W, TED W. There's a whole package in there. I'm happy to send it to you if you need it, but it's in the Governor's budget, the whole piece of it.

SENATOR KRUEGER: I just wanted to be sure.

SUPERINTENDENT VULLO: The ombudsman's not in there because it's not actually legislative, it's just appointing somebody in the department.

SENATOR KRUEGER: And is the assumption -- just very quickly -- that you could draw out of your revenues to cover the cost of the people needed to operate these programs?

SUPERINTENDENT VULLO: Oh, yes, yeah. We do it through assessments. All of the -- except for a very, very small piece of the agency, the agency is by assessments. So we would need FTE help for that, but we would do it through assessments of the licensed

entities.

SENATOR KRUEGER: Thank you. Thank you.

SUPERINTENDENT VULLO: Sure.

ASSEMBLYMAN CAHILL: We have been joined by Assemblywoman Nily Rozic, and she has a few questions.

ASSEMBLYWOMAN ROZIC: Thank you, Mr. Chair.

It's good to see you, Superintendent.

So I'm going to follow the line of questioning as the Senator just mentioned, because there is a piece that I'm more intrigued by in the student loan piece that is all about professional licenses. So can you speak to that a little bit? I know that other states across the country are looking at this issue as well, so maybe you can expand upon that.

SUPERINTENDENT VULLO: Sure. And thank you for reminding me of that, because there are other provisions in the Governor's budget -- they're not specific to DFS, but it's that no state agency can deny a license

or deny the renewal of a license because someone has not paid their student loan debt.

We don't believe that we're doing that today, but we know that in other states this is a problem and we should put this in our law, to prevent the denial of licenses or the failure to renew licenses just because somebody has a student loan. Because we know that when people have student debt, it carries with them for a very long time. And the last thing we want is to prevent them from being able to have an occupation where they can earn a livable wage so that they can pay back their debt, because that's really what we want.

And in fact there's a lot of the initiatives to address this. There's also a piece in the Governor's budget to require colleges to provide full disclosure of the terms for loans before students sign up. Last year we did a financial aid worksheet which provides that. So we're really trying to educate, but also addressing the predatory conduct that goes on and trying to get these

people who have the education to be able to earn a living wage and pay back their debt without onerous debt collecting, predatory activities at them.

ASSEMBLYWOMAN ROZIC: It's certainly an issue for my generation. And I know many people out there who have struggled with FANNY MAE over the years, so I wouldn't want to see them detrimentally impacted.

The last thing I want to mention, I know Senator Savino mentioned her support for the IVF coverage. I want to echo that sentiment. I think it's a big issue that we need to address, in addition to 3D mammograms.

And the last piece that really does impact a lot of women, it wasn't in the first part of the Council on Women and Girls, but I'm hopeful that you and I can work on eating disorders as they impact young women and men across the state. I have a bill that the chair of the Insurance Committee has helped me work through that would redefine biologically based mental illnesses to

include all sorts of eating disorders and not just anorexia and bulimia. It's a big issue that's impacting many women across the state. So I'd like to work with you on that as well in the future.

SUPERINTENDENT VULLO: Be happy to work with you on that. And it's obviously an important issue that we need to make sure that appropriate coverage is there. And so I'll be happy to look at that and see what we can do to make it happen.

ASSEMBLYWOMAN ROZIC: Great. Thank you so much.

SUPERINTENDENT VULLO: Thank you.

SENATOR HANNON: Senator Seward.

SENATOR SEWARD: Thank you very much.

I had just a couple of quick follow-ups.

Getting back to the health insurance tax issue, you stated in response to my earlier question on this that it was unclear how you could force premium savings from the tax reduction, the corporate tax reduction of these for-profit health insurers.

But you also stated that the higher rates -- their corporate rate was already built into your health insurance rates this year. Did I understand that correctly?

SUPERINTENDENT VULLO: No, what I was saying, Senator, is --

SENATOR SEWARD: You said that you were unclear whether you could get at the corporate tax cut to provide savings to ratepayers here in New York.

SUPERINTENDENT VULLO: What I was saying, Senator, is that when the insurance companies propose their rate increases -- and remember, my rate review is solely in the individual and the small group markets, which are community-rated. There are very few large groups that are community-rated.

The large group markets that are experience-rated, I don't have rate review over. And all of that, plus whatever other contracting that health insurance companies do make up the corporate entity that either itself is a taxpayer or is part of a consolidated group across the country that

has one parent company taxpayer.

So when I do -- but when those companies came out with their rates, I'm sure they took into account what their financial picture was, and they didn't think they were going to get a 14 percent tax cut. So it's not something that they accounted for. So it is a windfall, and it's found money that they didn't otherwise have.

When you look at my rate review and when you look at the medical loss ratio -- medical loss ratio, 82 percent is payment of claims, 18 percent is everything else, administrative claims and profit for that book of business -- so the individual market or the small group market, not the whole thing. And if I were to take into account federal taxes, taxes is a payment. This is a windfall, but taxes is a payment. And if I were to take that into account, what would happen is that the administrative expense piece of the MLR would go up, which could put pressure on the MLR in terms of claims and result in higher rates.

If that's what we were going to do as our overall rate -- we do take into account premium taxes. We don't take into account federal corporate income taxes, which are two different things.

SENATOR SEWARD: How would you be treating -- in rate-making for next year, how will you be treating this proposed new health insurance tax if it became law? How would that impact this process?

SUPERINTENDENT VULLO: Well, the proposal in the Governor's budget is to -- is the application of a fee, a 14 percent fee on the net underwriting gain at the corporate level of the company. And that's a number that is an equivalent number to an income tax number, net underwriting gains, like net income.

And so we would apply that 14 percent on the net underwriting gain. That money would be collected, and it would go to HCRA for the purposes of funding healthcare in the state budget. It's not a DFS -- I mean, we may -- we would make sure that this is

enforced, but it's money that would go to HCRA.

And that's what the calculation is. It's on net underwriting gain. It's -- it cannot be offset by, you know, 20 years of net operating losses or other things, it's just on that one net underwriting gain. That's the proposal in the Governor's budget.

So that's not part of rate review, it's a separate statutory proposal to collect that money.

SENATOR SEWARD: So you're telling us that it would have no impact on health insurance rates here in New York.

SUPERINTENDENT VULLO: The statute that's in the Governor's budget has an explicit provision that says that the insurance company shall not pass along this 14 percent to increase rates, and we will enforce that provision. But there's an explicit provision in that statute that they shall not.

And again, it's net underwriting gain, it's not premium tax. Premium tax generally

gets passed on. This budget provision explicitly says that the insurance company shall not pass it along to the consumer in higher rates. And we will certainly look at that. In the large group market that we don't regulate, they still have to abide by that law.

SENATOR SEWARD: And finally, I just wanted to reiterate my request in terms of -- I would be very interested to get the two-year history in terms of what fines have been imposed on -- in the P&C area, health, and life. You know, the number of infractions and the fines.

Because I think you were -- I would just like to have that information prior to making a determination on these dramatically higher fines that have been requested here.

I think you were much too modest in terms of what tools you would have at your disposal if an insurer is not paying claims and is providing misinformation and false information to the department. You and the Governor have the bully pulpit in terms of

press releases. You could create some very bad press for an insurer. You are the regulator of these companies, and plenty of tools at your disposal as the regulator -- you control the licenses of many of the people involved in these companies, and you have the power to do examinations.

So anyway, that was just a comment, not a question. But I think you --

SUPERINTENDENT VULLO: I'd like to respond to that.

SENATOR SEWARD: -- you were quite modest in terms of what tools you have at your disposal.

SUPERINTENDENT VULLO: Senator, I'd like to respond to that. Because if you have an insurance company that is troubled and has management that's not doing a good job and you have policyholders there, particularly those in long-tail-type coverage, meaning they're not going to get the benefit for some time, the last thing I want to do is use a bully pulpit to criticize the company and have the policyholders flee.

And you can't always, you know, exercise some of the other powers. The licensing power for an insurance company means that I can put it in rehabilitation or liquidation. It means I have to sign a petition that then becomes part of a court proceeding with the oversight of a Supreme Court justice, and it's a public proceeding as well.

So with some of these companies that are troubled and that have policyholders there, I have to balance the need to get the company to do the right thing without damaging the company such that the policyholders flee or -- you know, and if that happens -- again, if you have renewal-type policies, for example, healthcare is slightly different than P&C and, you know, other types of longer-tail policies. Life insurance is another one.

If you have policyholders fleeing, then you're going to increase the level of insolvency of the company. And then that company, if it has to go into liquidation,

you either have a guaranty fund or you don't, but the policyholder is not benefited from that. So increasing those tools and preventing some of the misconduct by having, you know, more of a deterrent on fines or the administrative supervision or the financial hazardous bill, is something that's important.

If I had the tools to do it with some of these recalcitrant ones, I would. But that's the balance that is struck. You can't just -- you can't just pull a license, because you have policyholders there that have policies that they're expecting some money from. And if the guaranty fund is hit, while they may get paid something that is an actuarially determined amount, all of the other companies pay for that guaranty fund for that company that goes under.

So as I said, these are not the majority of the companies, but there are ones that are difficult to deal with and create problems.

CHAIRWOMAN WEINSTEIN: Assemblyman

Cahill.

ASSEMBLYMAN CAHILL: Thank you, Madam Chair.

Superintendent, I have actually seven specific questions. I'm going to try to get them all in in the five minutes.

But is there specifically a compliance problem with EI in this state? Is there a compliance problem with insurance companies not paying claims or not doing so in a timely fashion?

SUPERINTENDENT VULLO: We have heard that, but I don't have any data on that.

ASSEMBLYMAN CAHILL: Regarding the fines, the tenfold increase in fines, how much were the collections in the last fiscal year for which you have information on the very fines that you're seeking to increase?

SUPERINTENDENT VULLO: As I said to Senator Seward, I don't have that number. And a lot of these fines come out of market conduct examinations that we don't make public, for good reason.

ASSEMBLYMAN CAHILL: But you have a

fiscal impact on them. You must know how much they generate -- I know you didn't know last year when I asked you the same thing. And apparently you haven't had a chance to do the research to find out what that answer is?

SUPERINTENDENT VULLO: Assemblyman, with all respect, I don't have the number in my head. It's not something I carry around with me. But I can get it back to you.

ASSEMBLYMAN CAHILL: It's not something you anticipated you would be asked this year because you were asked it last year.

With regard to the CVS-Aetna proposed merger, do you believe the Department of Financial Services has any authority over that corporate restructuring, over that --

SUPERINTENDENT VULLO: We do. We have approval authority, as does all of the states in which Aetna does business. We have approval authority over that transaction, and it's in the very early stages. And we're looking at it. It obviously raises a number of issues.

ASSEMBLYMAN CAHILL: Do you have any unique authority because of the state in which these companies are incorporated? I think Aetna is a New York company.

SUPERINTENDENT VULLO: It's actually domiciled in Connecticut, so Connecticut is the lead state. I actually saw the Connecticut commissioner last weekend, and we spoke about it, and there's going to be regular communication among the states that have approval authority over it. It's a very massive transaction that raises a number of issues. But we do have approval authority for purposes of the Aetna New York business.

ASSEMBLYMAN CAHILL: And what if the companies merge and the department determines that it's not in the best interest of New Yorkers? What is the impact on Aetna the insurance company and CVS the drugstore company?

SUPERINTENDENT VULLO: If it does merge?

ASSEMBLYMAN CAHILL: If you make a determination -- if the federal government

approves the merger and you decide that they will not be allowed to do business in New York in that format, what is the impact on the people of New York, particularly those who use Aetna for their insurance?

SUPERINTENDENT VULLO: The federal government's jurisdiction is antitrust. It's not an overall approval of the transaction. So when you had the Anthem-Cigna, for example, and the federal government sued, that was an antitrust complaint that the Department of Justice filed that killed that one.

So that's the federal government's role in the pure insurance -- you know, this is really a change of control application. It's not two insurance companies merging, it's a commercial entity acquiring an insurance company, so it's technically a change of control. Which every state who has a statute like we do has authority over, so we could say yes or we could say no or we can condition it.

And it's obviously a very complicated

transaction. You'd want the states to be somewhat on the same page. But, you know, it's certainly possible that some states can go one way and then other states go another way. I mean, I certainly hope not. But it's very early in the process. And it's a unique transaction because it's not two insurance companies coming together.

ASSEMBLYMAN CAHILL: Is DFS going --

SUPERINTENDENT VULLO: And it raises obvious, you know, issues with respect to pharmacy benefit managers, which I talked about last year.

ASSEMBLYMAN CAHILL: Is DFS going to be registering in with the Department of Justice on a position that the State of New York would be taking from an insurance regulatory perspective?

SUPERINTENDENT VULLO: It's not for us and the Department of Justice. The Department of Justice is not --

ASSEMBLYMAN CAHILL: In terms of the overall merger to determine whether it violates antitrust laws, it would be --

SUPERINTENDENT VULLO: That's not our jurisdiction. Our jurisdiction --

ASSEMBLYMAN CAHILL: I understand. I understand it's not your jurisdiction. My question was whether you were going to register the point of view of New York State with the Department of Justice as they were doing that review.

SUPERINTENDENT VULLO: Likely not, because I don't think this is an antitrust issue. I think it's an issue of whether or not this is a good new ownership for an insurance company.

ASSEMBLYMAN CAHILL: So you don't see an antitrust issue, okay.

SUPERINTENDENT VULLO: No, because I'm not the antitrust person. That's the attorney general, the New York attorney general.

I did manage that bureau when I was in the New York attorney general's office. It's not our jurisdiction.

ASSEMBLYMAN CAHILL: The next question is about the Fidelis proposal, Fidelis and

Centene. Absent new legislation, what is the authority of the department in regulating this conversion?

SUPERINTENDENT VULLO: So this is a transaction where both DFS and the Department of Health have roles. You have -- Fidelis is a Medicaid managed plan, so the Department of Health actually has the certificate of authority. The relevant regulation provides that the commissioner of health is to take a recommendation from the DFS superintendent, that's me.

In addition, the proposal includes a license that DFS would issue or not, so we have that approval authority as well.

And that too -- that transaction is a little bit farther along than the prior one that you mentioned, but we're in the middle of our review of that transaction. So we do have approval authority and recommendation authority, and DOH also has approval authority.

ASSEMBLYMAN CAHILL: Do you believe there's any need for legislation to create

the mechanism by which the State of New York would receive some benefit of the assets in the conversion? Or will existing legislation do the job?

SUPERINTENDENT VULLO: I think that looking at additional legislation is a good idea.

ASSEMBLYMAN CAHILL: Is the Governor going to propose any by Thursday in his 30-day?

SUPERINTENDENT VULLO: I don't know.

ASSEMBLYMAN CAHILL: Because I know he's counting on that money in the budget. One would assume that if he's counting on the money, he would want to be certain that he has the authority to actually get that money.

SUPERINTENDENT VULLO: I don't know about what amounts are in the budget or not. But I do know --

ASSEMBLYMAN CAHILL: $750 million.

SUPERINTENDENT VULLO: -- that the issue of the need for legislation is something that has been under active consideration.

ASSEMBLYMAN CAHILL: Madam Chair, if I could -- I know my time's expired, but if I could go with two more quick questions.

CHAIRWOMAN WEINSTEIN: Sure. Sure.

ASSEMBLYMAN CAHILL: The next one is, are there any refinements to the health tax to weed out those non-health insurers currently believed to be covered under the existing proposal? That would be the long-term-care insurers, the income replacement insurers, people like that who believe that they are currently covered under the Governor's 14 percent health tax.

SUPERINTENDENT VULLO: The concept of that fee is to capture the writing of health insurance to residents of the State of New York, and not to capture the writing of non-health insurance.

ASSEMBLYMAN CAHILL: Will it be amended to be clear, to make that clear? Because currently people --

SUPERINTENDENT VULLO: If it needs to be. I don't know whether it does. But certainly I'll take it back and look at that.

But it's -- there are insurance companies that are not health insurers that write accident and health plans. So there are life insurance companies, for example, and P&C companies that write some other kind of insurance and write health insurance. And the idea is to capture the plans, the writing of the health insurance plans, regardless of where the license is.

So a strict health insurance company has just a health insurance license. A life insurance company has a life insurance license that also allows it to write health insurance. So -- and there are P&C companies, a few of them, that also write health insurance. I'm not talking about long-term care, I'm talking about health insurance.

You know, there's some big ones that are not health insurers that are intended to be captured by this, for the writing of the health insurance piece.

ASSEMBLYMAN CAHILL: And my last question, regarding the comprehensive

contraceptive care legislation that you referred to in your direct testimony. That originated as an Attorney General's program bill under Attorney General Eric Schneiderman. Have you or the Governor extended the courtesy to Attorney General Schneiderman to ask for his input on the proposal to now roll it into the budget as a legislative proposal?

SUPERINTENDENT VULLO: I cannot speak to conversations that were had between the two. But we've had dialog with the Attorney General's office about that bill. And it's in the Governor's -- I don't know if it's the exact same bill, but there's a contraceptive care bill in the Governor's -- or he advanced legislation -- actually, I can't remember whether it's in the budget or he advanced legislation for contraceptive coverage.

ASSEMBLYMAN CAHILL: My question was just whether you've had conversations with the Attorney General about the proposal that's in the budget.

SUPERINTENDENT VULLO: Our staffs have

been in contact, yes.

ASSEMBLYMAN CAHILL: Okay, thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

We've been joined by Assemblywoman Gunther and Assemblywoman Seawright.

Mr. Hannon.

SENATOR HANNON: Thank you.

Superintendent, just as an aside, you had made a couple of mentions about the HCRA monies going to health. Just as a matter of fact, not all HCRA monies go to health. There is diversion -- and it's not just this year, though it's increased this year -- there is diversion to the General Fund. So it's not simply to be able to say, oh, yeah, I'll be helping the health. And that would -- that's actually part of my problem, you may have heard, with the health commissioner, that monies are not going to health.

A couple of different topics. Health Republic. You answered that pretty comprehensively, but you then finished by saying there's a suit that's going on that

you anticipate to be wrapped up shortly or soon or near future or -- I just wondered if there's any way to put some framework into that time limit.

SUPERINTENDENT VULLO: I wish I could. But we sued in September of 2017. There were a number of cases -- it's the risk corridors, mainly, that's created the legal battle, and there have been a number of cases at the trial court level that have been decided, and there were conflicting opinions.

There was an appeal to the federal circuit that was argued I want to say three or four weeks ago. I've actually read the transcript of that. It's unclear how that's going to go. But it's been argued. There are two cases, it was Moda and Land of Lincoln, and we await the decision of that federal circuit court, because I think that will inform -- hopefully it will be a good decision, but it's really uncertain.

And then, you know, obviously if that decision is favorable to the position of -- whether it's the department's or the health

insurance, because there are health insurance companies that brought these claims as well, then -- but if not, then we'd have to look to see.

We also have a reinsurance claim, and we have a cost-sharing subsidies claim that's separate from the appellate one. So we're moving as fast as we can, but that is a holdup.

SENATOR HANNON: Both of those claims, the reinsurance and the offsetting claims, would be adding to the corpus that's left for Health Republic?

SUPERINTENDENT VULLO: Yes.

SENATOR HANNON: And then last year you had talked about -- when you were contemplating bringing this suit, you said that there might be offsetting claims for New York against it. And did those develop? Did that become any cogent --

SUPERINTENDENT VULLO: Those are claims that the federal government may assert with respect to the loans that Health Republic received from the loan programs, the

federal government loan programs. And our position on that, so the complaints that we filed, includes the argument that there shall be no offset for those loans because our view is that any claims that the federal government would have under those loan programs, under New York law is subordinate to the claims of the policyholders, including the providers.

But that's something that has to be litigated. We don't know, but we expect the federal government to take that position. It would be nice if they don't. But that is intended to be part of the litigation.

And I think even with that, there's still some amount that we could collect. But the main thing is are we going to win on the risk corridors, because the overwhelming majority of that claim is the risk corridors claim.

SENATOR HANNON: Thank you.

Let me go to another topic, the Medical Indemnity Fund. We had had a roundtable on that last year. There was

subsequently a change in the administrator of that fund. We've received mixed reviews as to how that new administrator is doing.

One of the things that we were trying to avoid through the roundtable was not have the administrator simply apply Medicaid reimbursement rates. Otherwise, people would not go into the fund, they would just go take their -- roll the dice on a lawsuit and they could do no worse than Medicaid.

And I just wanted to know what type of input you're having from people who are making claims and people who are already in the Fund, because some of the people have come to us and said, just like you're talking about for other purposes, they could use an ombudsman to steer their way through whether or not they're getting correctly treated by the Fund.

SUPERINTENDENT VULLO: So, Senator, there was a transition in the administrator of the claims from Alicare to -- it was an RFP -- PCG. And in all candor, there were some hiccups in that transition process.

We've actually worked very hard to -- you know, to right that ship, and PCG has worked very hard. Some of those hiccups were due to the concerns that we had as to the prior administrator and some of the recordkeeping. There was some absence of W-9s, for example, and the right records.

No -- no family failed to receive the benefit. Any delays was the providers didn't get paid as promptly as they should have. So the benefits were all provided, it was just the providers did not always get the payments because there was more documentation, for example, that was needed.

I think we're in a pretty good shape now. We obviously are overseeing them very carefully. But I think we're in a decent situation now.

SENATOR HANNON: That brings me to a whole subject area of medical malpractice, which you've had administrative action during the course of the year on PRI. We hear outstanding that there is an offer from Berkshire Hathaway to buy MLMIC. I also know

the fact that one of the people -- one of the large institutions, SUNY Stony Brook, which had been covered by Academic, has withdrawn and formed their own.

I just wonder what is the general direction you are looking at for medical malpractice in this state, especially if we're going to have some type of bonus situation coming out of the Berkshire Hathaway purchase. And I presume it's a purchase.

SUPERINTENDENT VULLO: So the MLMIC situation is a demutualization, and so there would be -- there is a process for that that we're undergoing. Ultimately there would be a public event for that. And the owners of that company, who are really the subscribers, would have to be compensated for that transaction, compensated equal to -- equal or above their ownership interest in the company for that to be approved. So that's in process.

You know, medical malpractice, there are too few carriers. And certainly I would

like to encourage more carriers in this market. At the same time, it's important to shore up what we have. And so we discourage the SUNY Stony Brook situations, because what happens in some of those situations is you can get RRGs coming in and, you know, charging what they would say would be lower rates, but ultimately that's not good for the market, it's not good for the providers.

Because if you are covered by a risk retention group, we don't have oversight, that's another federal preemption, as I know you're aware. Not only do we not have oversight, but there's no guaranty fund, so the provider is not well-served by the RRG. And the plaintiff who might have a claim of malpractice is not served by the RRG.

So if that's where I use my bully pulpit, I do, to be against the RRGs. And the MLMIC transaction, I made that very clear, that that's not going to be an RRG.

So, you know, but if we can do more -- but we're doing our level best to manage this market. The companies that you mentioned, I

think we're doing our best to manage the situation, including with the administrative action that I took, which was a long time coming. And I think we're doing our best to right that ship. But we could still -- we need everybody to stay in the market.

SENATOR HANNON: I've had legislation restricting people doing malpractice in the state not to use an RRG.

But I would urge you to look at that demutualization as an opportunity and maybe to go beyond the statute and say, No, there's a bigger picture here, that we have to have a stable system in the state.

SUPERINTENDENT VULLO: Agreed.

And I think we've talked about your statute before, and I don't think it's a bad idea.

SENATOR HANNON: And the last thing is, you're not going to have any proposals on PBMs this year?

SUPERINTENDENT VULLO: I would still -- the bill that we proposed last year, I still think it's a good bill. And if

anyone wanted to take up that bill, I think the pharmacy benefit managers are still a black box, in a lot of ways, that just increases costs, and that providing for licensing of the PBMs is one way to tackle that.

SENATOR HANNON: Thank you.

SUPERINTENDENT VULLO: Sure.

CHAIRWOMAN WEINSTEIN: Assemblyman Raia.

ASSEMBLYMAN RAIA: Thank you.

I don't sit on Ways and Means, so I didn't get a chance to ask some of the questions that might be for them, but you seem to be the next best thing, and I just want to dovetail on some of the things that Chairman Cahill was talking about.

On the 14 percent, are there any other businesses that had a windfall as a result of the federal tax plan?

SUPERINTENDENT VULLO: Sure. Many.

ASSEMBLYMAN RAIA: We're not going after any of those, right?

SUPERINTENDENT VULLO: That's up to

you.

(Laughter.)

ASSEMBLYMAN RAIA: Okay. Well, we're talking about a Governor's Executive Budget proposal. I'm not done yet. But I thank you for your candor. I always do enjoy having a conversation with you.

The other thing is it's -- we came up with the 14 percent number because that's exactly what the reduction was.

SUPERINTENDENT VULLO: Thirty-five percent to 21 percent, yes.

ASSEMBLYMAN RAIA: Well, we all know that there's always other things that go into that number. So did we take into account all the changes with the federal tax plan, deductions, how the income is measured, which way -- you know, there's a lot of things that go into that. They may have a -- you know, it might be 14 percent, but there might be other competing things on that, so it's really not 14 percent.

SUPERINTENDENT VULLO: We're addressing the 14 percent with respect to

New York residents and healthcare for New York residents, and not -- and not the sort of national picture of what a consolidated tax return might be from a national/federal perspective.

ASSEMBLYMAN RAIA: Well, but the Governor quite clearly said the 14 percent tax on the health insurance is necessary because the federal tax plan, quote, unquote, transfers health costs to the state. But from everything I'm seeing, there's actually increases in Medicaid over time.

SUPERINTENDENT VULLO: I think there's clearly a reality that the federal government is using -- is applying tax cuts and then cutting domestic programs, including healthcare. The CSR subsidies have still not been paid. Finally, Child Health Plus, because of this Medicaid, is not something that we think is going to be --

ASSEMBLYMAN RAIA: You don't want to go up that aisle, because there are a lot of groups depending on that increase in the minimum wage bump that we still haven't

gotten to them -- nursing homes, assisted living. So, I mean --

SUPERINTENDENT VULLO: There's a lot of needs.

ASSEMBLYMAN RAIA: -- we drag our feet a lot too.

SUPERINTENDENT VULLO: There's a lot of needs in the healthcare space, and we think that it's an appropriate surcharge for a windfall that the health insurers are receiving, to put it into the state budget in order to address the healthcare needs of New Yorkers.

ASSEMBLYMAN RAIA: Fair enough. Thank you.

SUPERINTENDENT VULLO: Sure.

CHAIRWOMAN WEINSTEIN: I believe that's it for questions. So thank you for all the time you've spent here with us.

SUPERINTENDENT VULLO: Great, thank you. Thanks for having me.

CHAIRWOMAN WEINSTEIN: So we are ready to call our third witness today, the New York State Office of Medicaid Inspector General,

Dennis Rosen, inspector general.

And on behalf of myself and Senator Cathy Young, I do want to remind people that we do have your testimony that was emailed to us over the past couple of days, so we will be having a much shorter time period after the inspector general goes. And don't feel compelled to have to stay to be the last one. But we will stay for everybody who wants to participate today.

CHAIRWOMAN YOUNG: Welcome.

INSPECTOR GENERAL ROSEN: All set?

CHAIRWOMAN YOUNG: Looking forward to your testimony.

INSPECTOR GENERAL ROSEN: Thank you.

You have my full testimony before you. I'll read from an abbreviated statement.

OMIG's comprehensive investigative and auditing efforts, extensive partnerships with law enforcement agencies, and wide range of compliance initiatives and provider education efforts are projected to result in more than $2.4 billion in Medicaid recoveries and cost savings in calendar year 2017.

OMIG's recoveries were significantly higher in 2017. Preliminary numbers for recoveries including audits, third-party liability, and investigations total more than $485 million, which represents an increase of more than $67 million over 2016.

OMIG's cost-avoidance efforts continue to deliver impactful results for the Medicaid program, as preliminary 2017 data show a savings of more than $1.9 billion.

OMIG's teams of auditors, investigators, data analysts, and licensed healthcare professionals provide vital support and resources in collaborative law enforcement actions, which include takedowns of multi-million-dollar fraud schemes, criminal "pill mill" operations and drug diversion cases, as well as enrollment fraud prosecutions.

For example, OMIG played a critical role in a multi-agency takedown of a massive $146 million scheme operating out of Brooklyn that billed Medicaid and Medicare for thousands of medical tests and services that

were never done or were unnecessary.

As part of New York State's multifaceted response to the opioid crisis, preliminary data on OMIG's Recipient Restriction Program, which limits recipients suspected of overuse or abuse to a single designated healthcare provider and pharmacy, shows more than $77 million in cost savings to the Medicaid program was realized and, quite likely, many lives were saved.

OMIG's preliminary 2017 statistics regarding enforcement activity also show strong results. OMIG opened 3,224 investigations, completed 3,186, and referred 898 cases to law enforcement and other agencies.

As New York continues to transition from traditional fee-for-service Medicaid to a managed-care system, and alternative payment arrangements are introduced such as value-based payments, OMIG has developed and implemented new mechanisms to address fraud, waste, and abuse -- including match-based audits and data mining and conducting on-site

visits with managed care organizations to discuss program-integrity-related processes and procedures.

Further, as part of the agency's managed-care efforts, OMIG's Value-Based Payment Project Team works closely with other state agencies to identify potential program-integrity risk areas and effective measures to mitigate those risks as part of value-based-payment implementation.

To expand upon these efforts and provide OMIG with the tools necessary to provide flexibility to address program integrity issues as they arise, the Executive Budget includes authorization to enable OMIG to fine providers and managed-care organizations that fail to comply with the requirements of the Medicaid program. In the case of a managed-care organization, fines could also be imposed for failure to comply with its contract with the state. The proposals also would require managed-care organizations to refer all instances involving potential fraud, waste,

or abuse to OMIG, in conformance with federal law.

Additionally, OMIG's budget proposals seek to address managed-care recovery of overpayments paid to network providers by a managed-care organization. The proposals explicitly acknowledge that payments made by the Medicaid program to a managed-care organization, and from a managed-care organization to any subcontractors or providers, are public funds. This clarifies a misconception that once monies are paid by the state to an MCO, those monies are somehow no longer public funds and therefore not subject to oversight or recovery.

This provision would provide a mechanism for OMIG to continue to recover inappropriate payments from network providers. And if unsuccessful in those efforts, OMIG could require the managed-care organization to recover the amount from its network provider.

Going forward, as the healthcare landscape and the Medicaid program continue

to evolve and change, OMIG will continue to aggressively protect the integrity of the program, which is a key component in maintaining and sustaining the state's high-quality healthcare delivery system.

Thank you, and I'd be pleased to answer any questions you may have.

CHAIRWOMAN YOUNG: Thank you, Inspector General. We truly appreciate your testimony today.

And I just wanted to go over a couple of things. The audit target for this coming fiscal year is $1.19 billion, is that right?

INSPECTOR GENERAL ROSEN: Again, I'm having the trouble I've had in the past, hearing you in the well. But if you speak slowly -- I think you said $1.9 billion, that was our cost savings figure?

CHAIRWOMAN YOUNG: Yes, the audit target for 2019 --

INSPECTOR GENERAL ROSEN: That was for 2017, $1.9 billion.

CHAIRWOMAN YOUNG: Okay. So it's actually -- it says in the Governor's

proposal it's $1.19 billion, an increase of $300 million from the current year target of $1.16 billion.

The Governor also proposes to expand OMIG's authority to allow recovery of improper Medicaid payments made by managed-care organizations, MCOs, to providers. The proposal would require MCOs to report fraud to the OMIG and would impose penalties if they knowingly failed to do so. And the Governor also includes a provision that states that payments made by the Medicaid program to a managed-care organization, MCO, and from an MCO to any subcontractor or provider, are public funds.

So first of all, you've gone over some audit recovery targets and strategies for the coming fiscal year. Do you think that a $300 million increase is realistic?

INSPECTOR GENERAL ROSEN: Yes, I think it is.

CHAIRWOMAN YOUNG: And why is that?

INSPECTOR GENERAL ROSEN: The increase, I think, is realistic based on

enhanced technology that we've been using and other improvements in our techniques and our processes.

CHAIRWOMAN YOUNG: Okay. Thank you.

Do you think that the language included in the Governor's budget that states, and this is a quote --

INSPECTOR GENERAL ROSEN: I'm sorry, I'm having trouble -- I always have trouble hearing in this well. It's the only place in the world I do.

CHAIRWOMAN YOUNG: Yeah.

INSPECTOR GENERAL ROSEN: Can I come up there, and then I'll come back and I'll answer your question.

CHAIRWOMAN YOUNG: No, it's --

INSPECTOR GENERAL ROSEN: Or if you could speak up or do something.

CHAIRWOMAN YOUNG: Okay. Do you -- do you think --

INSPECTOR GENERAL ROSEN: Whatever you want to do.

CHAIRWOMAN YOUNG: I feel like a phone commercial: Can you hear me now?

(Laughter.)

CHAIRWOMAN YOUNG: Do you think the language that the Governor included in the budget that states, quote, Payment made by the Medicaid program to a managed care organization, and from those organizations to any subcontractor or provider, are public funds -- so that's the quote.

INSPECTOR GENERAL ROSEN: Yes.

CHAIRWOMAN YOUNG: Do you think that would create a precedent and allow for the same interpretation in other areas of the state budget?

INSPECTOR GENERAL ROSEN: I'm not familiar with that, other areas of the state budget. What I know is the Medicaid budget, and this is I think very well accepted language. But it has not been made explicit in New York State, and it's important that we do.

And the view expressed is that Medicaid funds paid to a managed-care plan are public funds. The managed-care plan is acting as an agent of the state, in effect,

certainly a contractor of the state when it pays those funds. And because of that, when it pays the money to a provider or a subcontractor, the nature of that money does not change. In fact, part of the Medicaid reimbursement to a managed-care organization is based on administrative costs on behalf of -- paid by the MCO toward a program -- not just medical care, but program integrity, efforts in protecting the money that's been given to them.

Whether or not that could be extended to other areas, I couldn't say with certainty. I know we have had discussions with people who are expert in the field, and they feel that at least with respect to Medicaid, this is an absolutely truthful statement. Other states have adopted this language too.

CHAIRWOMAN YOUNG: Okay, thank you.

Senator Hannon.

SENATOR HANNON: You mention in your testimony -- I'm sorry --

INSPECTOR GENERAL ROSEN: If you could

speak up.

SENATOR HANNON: You mentioned in your testimony the move to value-based reimbursement for providers, which is a major change from fee-for-service. And fee-for-service gave you as auditor, inspector, a chance to look at the contract, whether the service was delivered, and whether it was billed correctly.

Value-based payment is a whole different concept, saying that we're going to give outcomes as a result of the obligation to the provider. And so it does not have the four corners that you'd necessarily have with fee-for-service.

What you mentioned, that you've made adjustments in regard to your audits for value-based payment, I wonder if you could elaborate on that.

INSPECTOR GENERAL ROSEN: Well, that is really something that is still in process, as you know. And we're in constant contact -- we have a Value-Based Team that's an interdisciplinary team comprised of

auditors and investigators, we even have a nurse on the team, and they have engaged in discussions with the managed-care plans.

SENATOR HANNON: Actually, I think the nurse would be the most valuable addition.

(Laughter.)

INSPECTOR GENERAL ROSEN: And they have engaged in discussions with the industry and with the Department of Health, so we are on board with things as they go along.

But as you know, even from the Department of Health's point of view -- and it's been the Department of Health that's been promulgating the metrics -- things are still in the process of development. So that I think this is more a work in progress right now than something that I can point to and say, That's what it is and is going to be.

SENATOR HANNON: Are you going to be consulting with private industry which -- the private insurance industry, which already has in each of the insurance companies SIUs to look after fraud? And they themselves are moving to value-based payment, so there must

be some precedent also outside of government.

INSPECTOR GENERAL ROSEN: I agree, and we are also in regular contact with the SIUs for the managed-care plans. We have regular meetings with them, we talk about value-based payments, we talk about provider problems -- because if one SIU is investigating a provider who is part of their network and their plan, we need to know about it because that provider may be in lots of other networks. So communication has been the key, and we have stepped that up dramatically.

SENATOR HANNON: Thank you. Appreciate that. Appreciate your patience, too.

CHAIRWOMAN WEINSTEIN: Assemblyman Cahill.

ASSEMBLYMAN CAHILL: Thank you, Inspector General Rosen. I'll be brief.

I was a big fan of your transformation of the State Liquor Authority during your tenure there, and I was quite pleased that you were asked to serve in probably what is one of the most difficult jobs in the State

of New York, and that you said yes.

In your testimony, in your written testimony, and you touched on it in your oral testimony, you talked about your emphasis on the front end of the business here, the prevention education, the outreach that the office is doing. And I know that uncovering a fraud gets you a headline in the New York Times, and keeping a fraud from ever happening doesn't show up in the papers.

But in your estimation, have these preventive programs been bearing fruit? Have you seen people who might have otherwise or entities that might otherwise unintentionally get caught in the web not do so? And just talk a little bit more about your emphasis on the front end.

INSPECTOR GENERAL ROSEN: Sure. One of the statistics, ironically, that I'm most proud of -- and of course, you know, the emphasis has to be on the recoveries and the cost avoidance -- but nonetheless, one of the statistics I'm most proud of, which is in the full testimony, is the 90,000 hits to our

compliance portion of our website. It's not the whole website, it's just the compliance portion, which is basically educational kinds of materials for the industry.

We also do a lot of presentations to the industry. And I have seen a change, I've gotten feedback from people saying, Thank you for what you've been doing. Because as people have explained to me since I've been in this position, very often people do the wrong thing because they don't know what the right thing is.

And to be perfectly frank with you, my view as a regulator reflects my view as a person, and that is that I've never had anybody complain to me once in my entire life about not having a big enough pile of problems to deal with. And the one thing that I will do while I'm on this earth is, as a regulator and as a person, is not add to somebody's pile. The only time I will do that is when they're adding to other peoples' piles through their conduct. As a person and as a regulator, that's when I will intervene.

And, you know, we will -- we want to up our enforcement game where people are bilking the system. I want to have fining authority because right now, in almost every case, all we can do is take back money if you've done something wrong. We can't have a deterrent in place so maybe you'll think twice about not doing something wrong in the first place. So in those instances, I will act and I will act strongly. But I don't want to make anybody's life more miserable, whether it's an MCO, a provider, or my next-door neighbor.

And I will make every effort before we take any action to educate the provider, the person, or the MCO on what the right thing is to do so they don't get sandbagged. I don't believe in doing that.

And thank you for the compliment with respect to my tenure at the Liquor Authority. And I remember one of the things I did there which I've done to some degree here is I spent a year giving the industry a message that we were going to tighten up enforcement.

And I did a lot of presentations, a lot of conversations, and we did some record enforcement at the SLA, and overall there were no complaints.

We also changed laws that were unreasonable from the Prohibition Era -- when we came out of Prohibition and they first established the agency. Because they were unfair, they were unreasonable. That's what I'm trying to do at OMIG.

We are talking about fines in our proposals because you need to deter bad behavior. Right now, all you can do is just take the money back. If somebody's doing 90 on the 787 and they get stopped by a trooper, the chances are just apologizing isn't going to get them off the hook. He's going to give them a ticket.

ASSEMBLYMAN CAHILL: I'd better make a note of that.

INSPECTOR GENERAL ROSEN: And you can argue that, oh, he's raising money for government, and he is. But the primary purpose in writing that ticket is to deter

this person from doing 90 miles per hour again. Because if people were told that somehow the state troopers have changed their policy and nobody gets a speeding ticket anymore, I think the 787 is going to be strewn with dead bodies for quite a while until that policy changes.

And it's the same thing in what we're dealing with. I want to deter bad behavior. If I can deter it, I'd rather do that than punish it. And if we deter bad behavior, then that's good for the good providers and the good MCOs and the needy recipients. And it's good for the taxpayer. That's all I'm trying to do.

ASSEMBLYMAN CAHILL: Well, thank you so much. If there was a way to give you the ability to issue fines that could sunset on the end of your tenure, I would be 100 percent for it. I'm a little concerned about --

INSPECTOR GENERAL ROSEN: You know, it's funny you mention that, because when I was at the State Liquor Authority I had a

proposal to give the -- the Liquor Authority is governed by a chairman and two commissioners. And the power was very diffuse, and over the years that was one reason why it had been very inefficient in a lot of ways. And we put in a bill that would give the chairman, me, all the administrative authority -- not the regulatory authority, that would still be shared. And people were very leery about it, because that agency had had a history that gave some people pause. And the bill was passed with a three-year sunset.

But I will tell you that I was there once when it was renewed, and since I've left and somebody else is there, it's been renewed. And the thing about --

ASSEMBLYMAN CAHILL: He's a very good commissioner and a constituent, so --

INSPECTOR GENERAL ROSEN: And I agree. I'm familiar with him.

And I will tell you that the fining proposal that is included in the Governor's budget, there are very clear restrictions on

how the agency would do it. One, no fine would be issued without prior consultation with the Department of Health. Two, there's a listing of eight or nine criteria that we would have to consider, things like how culpable was the provider, whether there were factors beyond than provider's control, did the provider have prior violations, how large is the provider -- you know, because that might impact the amount of a fine that would have some deterrent value. Very clearly laid out.

Also in the budget proposal there's a clear commitment to draft regulations, if the bill is passed, in consultation with DOH that would make very clear what the specific violations are, what the fines are, what the range of fining would be, and what the due-process rights would be.

Right now, in the model contracts with the MCOs, there are provisions for fining them because the federal authorities in 2016 passed regulations that tightened things up when it came to managed care, for example,

and among other things they wanted provisions in the managed-care contracts that said penalties and fines could be taken. But it's very amorphous. It's very vague. We want -- the purpose of this proposal is to clarify that, to make clear if you do this, this will happen, and here are your rights.

Again, to actually to circle back to your initial compliment, which again I do appreciate, it will tell people clearly what the rules are, and there's no reason for violating them, if you've looked at it. There's no legitimate reason. And again, we need fines so that people -- good providers who are hard up for money these days aren't strewn along the highway like dead bodies because somebody is driving 90 or 100 miles an hour and nobody is stopping them.

ASSEMBLYMAN CAHILL: Thank you.

CHAIRWOMAN YOUNG: Anyone else?

Senator Hannon.

SENATOR HANNON: The point about all of that, I think, is we don't have to go to granting that power when we should be

insisting on those provisions being in the contract, and that's what commercial entities do. They have contracts, they have penalty clauses, they have failure to perform, they have all sorts of reasons that are laid out specifically instead of leaving it to regulatory agency. I think that would be a far better approach. The firmer we can be, the better. And to do it up-front instead of doing it subsequently, so we don't go through what we have -- sometimes, with your predecessor, retroactive five and 10 years -- revised standards that come about.

But I do believe that the public monies is the public monies, and we have to be firm about it. But the most transparent we can be is to set it forth at the beginning.

INSPECTOR GENERAL ROSEN: I think there's limits to what you can do in a contract sometimes because we're negotiating with the people that, as you know, that we're overseeing. We're negotiating with the people who we're going -- with the people --

some of whom may be fined as a result of this if they do engage in bad conduct. So that I think when it comes to the specifics, rather than take the next two or three years to negotiate a contract, I think New York State needs to make a statement now.

As to the fact that the one agency that's been singled out in statute to deal with fraud, waste, and abuse in the Medicaid system -- OMIG -- has the authority to fine, I think that needs to be made clear by New York State.

I think just that we can take money back that is inappropriately gotten by a provider isn't enough. And I think that's a statement actually for you folks to make, that I'm asking you to make. I don't expect the providers necessarily to make it.

And again, there's language -- you're familiar with the -- I know you're brilliant when it comes to these issues. You're familiar with the MCO contracts, and you know what's in there. But it's very general, it's very vague, because to negotiate a good

specific, clear provision is going to take forever. And the system doesn't have that time. That's a luxury. I don't think that our Medicaid program can afford it, not if we want to take care of the people in it. And again, when I say the people in it, I'm talking about the good providers, the needy recipients, and the taxpayers who are footing the bill. And I don't see an excuse for us not to do it legislatively.

In my prior experiences -- years at the AG's office, my time at the SLA -- I dealt very much with the securities industry, the insurance industry, at the SLA, the liquor industry -- I could go through a whole list of the industries that I had very, very significant interactions with, and lawsuits.

When I came to OMIG, I was totally flabbergasted that this was the first regulatory agency I'd seen that didn't have real fining authority. There are a couple of very narrowly drafted provisions and regulations in Title 18 that give us very, very narrow fining authority with respect to

fee-for-service, but it's something that's never been used because it's unrealistic. I don't know of any other regulatory agency with comparable responsibilities that doesn't have that as a tool.

CHAIRWOMAN YOUNG: Thank you.

And I'm sure we'll have further discussions on this issue, so we appreciate you being here today, and again, it's always great to see you.

INSPECTOR GENERAL ROSEN: Thank you very much.

SENATOR KRUEGER: Thank you.

CHAIRWOMAN YOUNG: Thank you.

Our next speaker is the Healthcare Association of New York State, HANYS, Bea Grause, president.

Welcome.

MS. GRAUSE: Welcome.

Thank you, Madam Chairwoman, and members of the Senate and the Assembly. I appreciate your time and perseverance today. I will be brief.

I wanted to thank you for your

thoughtful questions and also thank the Governor for what we think is a good start to the budget that shares our priority of protecting and strengthening New York's healthcare system. I'll identify four areas of support and four areas of concern.

The first, in the areas of support that you've talked about quite a bit today, is a Healthcare Shortfall Fund. We do think there is reason for that because we think there are continued threats on coverage, undermining coverage, such as what Ms. Vullo said around the association health plans, and continued threats to payments to providers.

The second item is we support the capital funding, the $425 million in capital funding, that has been part of a series. And again, I think it's very needed by our providers. We also support continued funding for the distressed hospitals, the VBP QIP, the VAP-AP, and the safety net funding for our hospitals, both rural and urban. And we support the expansion in the scope and use of telehealth that is occurring through the

regulatory modernization initiative.

The four areas of concern are the $425 million that has been transferred out of the global cap, the proposal that was in the last year's budget that was removed eventually; the potentially preventable emergency room visits, the $15.7 million cut; also, as has been discussed before, the nursing home cuts; and the cuts to the quality pool.

So with that, I'm happy to take any questions.

(Laughter.)

MS. GRAUSE: Okay. Thank you.

CHAIRWOMAN YOUNG: We always appreciate your input very much --

MS. GRAUSE: Thanks.

CHAIRWOMAN YOUNG: So thank you for being so patient today.

CHAIRWOMAN WEINSTEIN: Thank you.

(Discussion off the record.)

CHAIRWOMAN YOUNG: Next we have President Ken Raske, Greater New York Hospital Association.

How are you?

MR. RASKE: I'm fine, thank you.

CHAIRWOMAN YOUNG: Glad to have you here today.

MR. RASKE: Thank you very much. It's always nice being with you at this annual event, having an opportunity to comment on matters of great importance to the healthcare community.

I have the pleasure of -- have joining me this afternoon, Dr. Steve Safyer, the head of Montefiore Medical Center in the Bronx, a world-class institution and dedicated to a lot of the issues which we pride ourselves in.

The testimony that I provided to the members of the committee is in a panel form, and I can walk you through it pretty smartly so that we can save time and then focus on some things that really need to be clarified for all of the members.

To begin with, we start off by saying, you know, that there are 27 hospitals that are on a watch list of the Department of

Health. I'm not sure if the commissioner spoke to that issue this morning, but 27 is quite a few. And they're scattered all over the place, from the western part of the state through -- including, obviously, New York City. Senator Hannon, there's none on the island as of this point.

But when you move to the next list of institutions, those are the near-watch-list institutions, and there's about 30 of those, again scattered all over the state. And they are identified by having a low commercial insurance base, having a lot of Medicare government payers, Medicare and Medicaid, overall negative margins or near-negative margins.

So that is another 30 institutions, and by the time you get -- if you start adding them all up, you've got about a third of the hospitals in New York State are in fragile condition.

Now, part of what you see here when we move to Panel 6 is the Medicare and Medicaid payment-to-cost ratio. If you have a lot of

Medicare and Medicaid -- and I believe, Dr. Safyer, you will attest to this in your portion of the testimony -- you're in trouble. When they pay below cost -- in the case of Medicare, 82 percent; in the case of Medicaid, 86 percent -- that is not a financially viable model if you have a lot of government payers. And that is an absolute fact. Viability only occurs when you have a substantial commercial base.

But ladies and gentlemen, things are changing. Go to the next panel. Here we see the percent of discharges that have gone on Medicare and Medicaid and have grown over the last 10 years. And at the same time we're looking at the commercial base dropping. So the ability to cost-shift, which has been a viable option for some institutions, is diminishing.

One step further, if you go to the next panel, what we're seeing on the commercial insurance base is the proliferation of high-deductible plans. What does high mean? Well, probably for the

single coverage, 1200 to 1500 bucks. For a deductible for a family it could be 3,000, it could be more.

So now what does that translate to? I can tell you what that translates to: $720 million worth of bad debt for New York State hospitals last year, and growing. Bad debt.

So I have a proposal, the first one for you today. I have a proposal to reduce hospital bad debt, and here it is. It's on Panel 9. Require private insurers to reimburse hospitals for bad debt incurred on behalf of their enrollees. This is a real winner. And to show you that you can actually do this -- Medicare does it now. Follow the lead of the federal government and this will then bleed off some bottom-line pressure that institutions have.

I have more proposals for you. Now let's turn to Panel 10. Our future economic situation is defined by two variables going forward, ongoing threats from D.C. and then no Medicaid trend factor for the past decade.

Lets drill down to both of them.

On Panel 11 you hear the good news: CHIP reauthorization. God bless CHIP reauthorization. Medicaid DSH was done too, the next panel. That's why it's shaded in orange. But here's the problems. One, Medicare DSH cuts are clocking in at $600 million a year. Senator, I know you questioned that earlier -- we are actually experiencing a third of that right now. It is draining off of his bottom line and draining off of the others across the state.

340B program, outpatient drug subsidies, that is a $50 million hit. The loss of the CSRs, the cost-sharing reductions, $975 million.

Tax reform. Now, who would have thought that we would have a tax reform problem in relationship to the hospitals, since they're tax-exempt? Except for one little thing -- I've been holding the SALT provisions aside for the moment -- we're going to be taxed now for our employee benefits that we're providing for transit.

Up to $260 a month, it's now going to go back to the employer -- the gentleman to my left is an example -- for each employee that is provided a transit benefit in many urban areas that's done across the United States.

Finally, hang the bell on the cat on this one. This morning we got great news. The president of the United States decided to release the U.S. budget, and you have two boxes that need to be filled in right here, entitlement and then Medicaid. Well, let's fill them in. GME is being cut to the tune of $48 billion in the president's budget. Translate that national number to New York State -- we produce 15 percent of all the residents in the United States, you all know that -- well, that's $7.2 billion over 10 years. That is in the president's budget this morning.

Also in the president's budget, Medicare DSH cuts again of $70 billion and a bad debt cut sitting there at $37 billion.

So the bottom line is we're under siege. I call it economic tyranny from

Washington, and that's exactly what I said in a statement this morning. And it just doesn't end. It's been 12 to 14 months of this, and it just keeps on getting worse.

Let's go to Panel 12. Here's Medicaid domestic, your responsibility in terms of policy formulation. We haven't had a rate increase -- we haven't had a rate increase for 10 years. What I've done here is simply deflated -- a Medicaid dollar 10 years ago is now worth 75 cents today. Seventy-five cents. And I have labor costs, and we want to be fair to labor because we must be, because they're the backbone of the healthcare community, and we have to pay them fairly and justly. And I'm a big supporter of doing that, and how are we going to do that when you have this kind of situation? You just can't do it.

So the Governor in his wisdom put together a budget, a budget which we support, but we have some suggestions for which we would like your help on. He is proposing a $1 billion Healthcare Shortfall Fund. And

that shortfall fund addresses the D.C. cuts as well as the Medicaid rate increase problem.

The problem with it, as I do the math, ladies and gentlemen, I would argue that the fund should be $1.5 billion. So my second suggestion to you is to increase it from 1 billion to 1.5 billion. So that is the second suggestion on top of the bad debt suggestion that I had earlier for insurers.

Also in the Governor's budget is a $425 million proposal for capital funding for transformation and value-based payment participation and the like. We support that.

Finally, in conclusion, members of the committees, you know the Executive Budget also proposes to continue to fund the watch list institutions, we support that; extends the Indigent Care Pool allocation for one year, it needs to be reexamined thereafter; and continues safety net proposals.

Finally, on med-mal, the Executive Budget proposes to change the interest rate requirement that currently sits in statute at

9 percent to basically a market rate. And that would obviously drop it. Now, where does that come from? That comes from when a decision is made in the court about a malpractice case and then it goes to appeal, that would be the time frame that this thing would kick in -- what interest rate are you going to charge. The Governor's proposal is suggesting that.

And then, finally, we have some issues as it relates to deposing expert witnesses. We think both sides should be able to do that -- plaintiff, defendant, it doesn't make any difference. It's a good thing for the country.

So with that in mind, that is what I've outlined. This is our statement of fact, our statement of proposals, and we really ask you to support it as you continue your deliberations.

Madam Chairman, I would now defer to any questions or to my partner, Dr. Safyer.

CHAIRWOMAN YOUNG: Thank you. I think Senator Hannon has a question.

SENATOR HANNON: I had a little trouble following it. You gave me an unnumbered set of panels.

MR. RASKE: Well, you know staff work ain't what it used to be, Senator.

(Laughter.)

DR. SAFYER: Kemp, you need your eyes checked. You need your eyes checked, Kemp.

MR. RASKE: I'm sorry, I forgive you for that.

SENATOR HANNON: So I'm trying to best follow -- are you suggesting that there be a Medicaid increase this year?

MR. RASKE: Oh, absolutely.

SENATOR HANNON: And how would that be structured? Among which providers, and in what percentage?

MR. RASKE: Well, Medicaid by definition goes to Medicaid institutions. And since Medicaid institutions -- since we've seen the growth in that payer source, there would be natural gravitational pull no matter what you did to where the Medicaid business is at. This is all by definition.

So therefore, a rate increase of sufficient magnitude would be necessary that would then drive into that government payer source and also, as a result, help buoy -- raise the boating level there, the water level, so that you get more financial stability. So that's exact how the proposal would work.

Now the question is how much. And the answer is I'm not prepared to say that at this particular time.

CHAIRWOMAN YOUNG: Thank you. Anyone else?

Okay. As always, we truly value your input and appreciate you being here today.

MR. RASKE: Well, thank you.

CHAIRWOMAN YOUNG: Thank you.

MR. RASKE: Like I said, it's always a pleasure. And next year we'll number the pages, sorry.

CHAIRWOMAN YOUNG: Yes, we need them numbered next year, Mr. Raske.

MR. RASKE: All right. Thank you.

CHAIRWOMAN YOUNG: Thank you.

Our next speaker is Helen Schaub, New York State policy and --

DR. SAFYER: Oh, wait, wait -- forgive me.

CHAIRWOMAN YOUNG: Oh, okay.

DR. SAFYER: Dr. Safyer.

CHAIRWOMAN YOUNG: I'm sorry, Doctor. Do you want to say something?

DR. SAFYER: If that's okay.

CHAIRWOMAN YOUNG: Okay.

DR. SAFYER: I'm going to be brief, and the key to that is my opening prepared remarks says "good morning."

(Laughter.)

DR. SAFYER: So I'm going to skip the "good morning," yes.

I appreciate being here. I want to build upon what Ken has to say, and then to some very definitive extent I want to answer Kemp's question about Medicaid.

So Montefiore Health System and the Albert Einstein College of Medicine together make Montefiore Medicine. And these are two institutions that have come together and make

up an academic medical center that is very unique in many, many ways.

So how is it unique? It serves four counties -- the Bronx, its home; it serves Westchester, Orange, and Rockland. There are about 4 million people in our footprint, and we take care of at least half of them on a regular basis. And we do that through a number of platforms which are also unusual for an academic medical center because we have a very, very large primary care platform.

Two hundred and fifty sites provide the care in the community where people live. And we do, in those 250 sites, 5 million visits a year -- half of them are primary care and/or GYN or maternity. That is unusual.

Two, we do everything that's done by the other important institutions in town, which means we do everything that is complicated -- very necessary cancer care, the most advanced heart -- the most advanced. We are the only other lung transplant program

in the lower part of New York State. And if you watch CNN, and I bet a lot of you are addicted to it now, you might have noticed that we separated those two twins that were conjoined at the brain and the head, and that is the fifth of seven successful ones in the history of medicine.

So we do very, very complicated care. And here's the punch line, and it goes back to what Ken was saying. Over time, our payer mix has become more troubled. Part of that is the cap on spending and Medicaid in facilities that we run for 10 years. And that happened at the same time that pharmaceutical prices have some years gone up 12 percent. The vendor prices are averaging 5 to 7 percent in rise, and the withholds from the private insurance companies are through the roof. We're owed, at any one time, $150 million from the big three. To be owed that is a loan without interest, and it is very challenging.

To cut to the chase, most institutions that have Medicaid at all underwrite the

losses 65 cents for a dollar's worth of what it costs us. Medicare is about 70 cents on the dollar, so there is an underwriting need that you fulfill with more commercial insurance. Our footprint doesn't yet have that kind of commercial insurance to underwrite it.

How have we gotten through this all of these years? Kemp helped us one way. We have moved boldly -- and that was in '95 -- boldly into value-based purchasing, taking risks and getting rewarded when we keep people out of the hospital, not take them into the hospital. That has allowed us to basically close many, many beds -- which is a mandate for the state -- keep people healthy in the community, and get higher up on the premium stream so we keep more.

If you're 85 percent Medicaid and Medicare and 15 percent commercial, it is extremely challenging. Those 5 million ambulatory visits are actually 60 percent Medicaid and 20 percent no-pay.

So the combination of turning

hospitals around that were failing, repurposing hospitals that were failing -- Westchester Square -- building hospitals -- we have a 300,000-square-foot hospital without beds in the Hutch Metro Center. Our platform has allowed, through shared services and overarching redirection, to bring back New Rochelle, Mount Vernon, work with Our Lady of Mercy -- which is now a going concern in the Bronx, it's called Wakefield now -- and many, many, many others, and the Health Department keeps engaging us to take on affiliates.

So at this moment we are 40,000 employees in that arena, we're 55 percent organized, NYSNA's here, 1199 is here -- Montefiore was the birthplace of 1199, and we were paying $15 an hour three or four years ago to all our employees, so we pay a living wage. Forty thousand people, of which 15,000 people live in the Bronx -- that is the economic engine of the Bronx, that is how the Bronx turned around from a 17 percent unemployment rate in the recession to what it

is today. One in five in New York State work in healthcare. In the footprint I'm describing to you, it's probably higher.

So -- and this is the punch line. I don't see how the state can supply a fix for Medicaid everywhere that Medicaid is used. But, you know, I could be wrong. But where you are successful and you are moving towards a model that actually is changing the way we do healthcare, we have 400,000 lives in that risk-taking arena right now. We were the most successful pioneer institution in the country in Obamacare, and we just were named by Jason two days ago as an innovator program where we can get further up on the Medicaid revenue stream. But we need a fix for now. And I believe a carrot should be something that you use to incent high Medicaid institutions to get higher.

So here -- final, final, just so you have some ability to navigate this. If you took our payer mix and replaced it with the four other big institutions that do the same things we do that are outstanding

institutions in town with medical schools, our bottom line would move from a 1 percent or 1.5 percent to a 10 or 12 percent.

One institution's payer mix at what we get paid would add a billion dollars to our bottom line. So I'm not asking for a billion dollars, I'm asking for some ability to make this very important experiment. And I think an institution that is blazing a new way to do healthcare, bringing it into the community, keeping people well, keeping them out of the hospital, is worth your consideration for investment.

I'll stop now.

SENATOR HANNON: Well said.

CHAIRWOMAN YOUNG: Thank you.

Senator Savino.

SENATOR SAVINO: Thank you.

I just have a question. First of all, thank you for your testimony. And last Friday I attended a briefing at Richmond University Medical Center on the effect of the Governor's budget on our local hospitals, and David Rich was there, and I see Helen

from 1199, and the nurses were there, and we got a snapshot of just what it will do to local healthcare delivery for Staten Island University and for Richmond. So I want to thank you both for being here and sitting through that.

In your testimony, though -- in your slide on Number 19, the numbers are here in the corner, okay, in the gray -- you referenced hospital drug costs growing, it's almost a 40 percent increase just in two years. So I was wondering if you have an opinion on the issue of the opioid surcharge.

When we took testimony the other day at the revenue hearing, we didn't get a clear answer as to who's actually going to pay that surcharge, and there's a concern on the part of hospice providers and on the part of hospitals and other -- because you purchase drugs, it's one of the big costs, as you pointed out in your testimony --

MR. RASKE: Oh, yeah.

SENATOR SAVINO: Has there been any discussion about how to hold the hospitals

harmless from the increase, this surcharge on opioid purchases? Has anybody spoken with you?

MR. RASKE: You know, that's an excellent question. I don't have a good answer for that.

Our struggling with the drug prices -- we do have a group-purchasing operation that's actually national.

SENATOR SAVINO: Mm-hmm.

MR. RASKE: And I think we do the purchasing, Steve, for Montefiore.

DR. SAFYER: You do.

MR. RASKE: Which uses enormous market muscle when we put it in that context. Yet we're still seeing the kinds of price increases that we're seeing here.

But I know, Senator, that's really an important question. I don't have a good answer, but I can give you an answer on it and some ideas on how to tackle that, to help that -- hold the hospitals harmless on it. It's a great idea.

DR. SAFYER: Can I just add to that?

MR. RASKE: Please.

DR. SAFYER: In my opinion, if we could use Medicare to discipline the pharmaceutical companies, it would be over in one night. So we would go from this enormous increase in what we're paying in the aggregate -- which is for off-patent drugs, some of them having to do with the opioid crisis in terms of being therapy -- all the way to the drugs that are brand-new and highly complex and very innovative coming from our medical schools.

I don't think that's going to happen in the next two or three years. Medicare being disciplined.

SENATOR SAVINO: Mm-hmm.

DR. SAFYER: So the State of New York in many different ways -- the pharmaceutical companies cannot abandon this market, period. And we need to show them that we can discipline what they do. And I would urge us to tax what we can and/or force them to not continue to do what we are watching all the time in the news.

And the second thing I just want to say, the opioid effort on the national basis, I don't think I have to convince anybody, is tepid at best. It's nothing. The Bronx never got better. It's the same heroin epidemic, it just says fentanyl now. I mean, it never went away.

Kentucky understandably is new. But in our footprint right now we have St. Luke's-Cornwall, which is arguably a rural hospital. And in that neighborhood and that community we are seeing things through the emergency room that are horrific. It's not five out of seven days there's a death -- which is the Bronx -- but it is moving up in those communities. So I think we need to take action on that.

SENATOR SAVINO: Mm-hmm. I agree. I spoke at the meeting on Friday about the repeat performances in the emergency room of people who are not necessarily using heroin and fentanyl on the street, they're using prescription drugs that they get their 30-day supply and go through them in a week, and

then they wind up in your emergency rooms and they go through withdrawal, and then we send them on their way and they go back home and they do it again every month.

MR. RASKE: Yes.

SENATOR SAVINO: And I think there has to be some analysis of the costs on the hospital system for providing short-term detox in the emergency room until people come back again next month.

MR. RASKE: Correct.

DR. SAFYER: Yes, Senator.

SENATOR SAVINO: Thank you.

CHAIRWOMAN YOUNG: Senator Hannon.

SENATOR HANNON: I think your point about the federal government is correct, but it just doesn't go one way or another. First of all, that is very devastating news about graduate medical education --

DR. SAFYER: Terrible.

SENATOR HANNON: -- which is an extraordinary revenue source that has not been on the radar in New York.

DR. SAFYER: Right.

SENATOR HANNON: Second, though -- but at some point, sometimes they give instead of just take away. I also read that they changed the 340B drug subsidy and they took it away from just 340B hospitals, but they took that money and gave it to all hospitals. Now, how that benefits or not -- the changing dynamic of policy is probably overarching above the dollar figure, trying to figure out where you're going to put your footprint and where you're going to go forward. And the academic medicine which had been the hallmark of New York really has to be really argued for very strongly.

So whether you numbered the pages or not, I think --

(Laughter.)

SENATOR HANNON: -- I think, President Safyer --

MR. RASKE: I can see I'm not going to live this down.

SENATOR HANNON: Neither am I.

-- I think your point about Montefiore -- and you took -- you have the

hospitals not because you went there and said, We want to acquire hospitals, but rather the State of New York said to you: Please take these hospitals.

So it's the state's obligation to continue in a strong way, and I think those are points well-made.

MR. RASKE: I'm not going to debate the issue on the GME, but I do want to -- just one fact. The way the proposal of the Executive is coming out is that they will take all the money from Medicare and GME, all the money from Medicaid and GME, all the money that comes from the child health programs and GME, pool it, cut it, and redistribute it.

So when you sit on a situation where New York State produces 15 percent of all the residents in the United States, the outflow, Senator, will be astronomical. I just did proportionality: $7.2 billion out of New York. And where is it going to go? Outside of the cut that would be in, it's going to flow across the United States. And

that's the way it is.

And Steve, forgive me, I just wanted to elaborate.

DR. SAFYER: No, no, no.

MR. RASKE: That's what we understand this proposal is.

SENATOR HANNON: Thanks. The chairs of Finance who are over to my left, your right, know that we have 35 more witnesses today. So I should be quiet.

CHAIRWOMAN YOUNG: Thank you. Thank you for being here.

DR. SAFYER: I've got to make one comment, and then I'm leaving. I do.

GME is not just not just a resource for the institution. It's how we bring people to New York and to footprints, like I was describing. One-half of the physicians working at Montefiore, anywhere, train there or went to med school there, 1500 at any one time. That's how we recruit them.

SENATOR HANNON: Thank you very much.

MR. RASKE: Thank you.

CHAIRWOMAN YOUNG: Thank you.

Our next speaker is Helen Schaub, New York State policy and legislative director, from 1199SEIU United Healthcare Workers East.

She brought her fan club with her.

MS. SCHAUB: We had a few more folks here, but unfortunately they had to leave.

But thank you for having me. I wanted to -- I'll be brief, I know there's a lot of folks who are waiting to testify. I wanted to just make a couple of points related to the discussion that we were just having and then talk about a few of the long-term care proposals in the budget.

So our organization has spent much of the last year doing battle in Washington -- all around the country, really -- to talk about the devastating impact of the cuts that have been coming at us. We have fought a lot of them off, but certainly not all of them. And the ones that remain are very serious, and I think that's why we're supporting the Governor's proposal around the shortfall fund, although we'd like to see it a little

bit larger.

As the previous speakers mentioned, we have Medicare DSH cuts which are already happening. We have the cost-sharing reduction payments which have already happened. And then even though presidents' budgets are not generally enacted as written, putting very serious Medicaid cuts on the table -- which the president did this morning -- we think reanimates the discussion that we were having, the bitter battle that we were having all last year around Medicaid cuts, and we're very concerned that a Cassidy-Graham or some of these other proposals that would cap federal Medicaid spending are going to be revived by what the president has put on the table.

So the federal threat is very real. We've been combating it every way we know how all around the country, but we know that we need to take steps here in New York to protect New Yorkers, and we think the shortfall fund is the right way to do that.

We also think that it can address,

really, the underlying crisis that we were talking about that previous speakers were talking about in terms of the lack of increases in Medicaid rates for the last 10 years. You know, we get calls really almost on a weekly basis from institutions saying we're not sure if we can make the benefit fund payment, we're not sure if we can make payroll -- and we're scrambling to try to put together some sort of aid. It's the 27 watch list hospitals, which are urban and rural, they're all over the state, and the others that are on the brink. It's because of the structural deficit.

The more you depend on public payers, the more that you are just losing money every day you keep your doors opened. And we think having a shortfall fund is an opportunity not only to fend off some of the impact of the federal cuts, but to strengthen our provider systems.

Our union has been in favor of transforming the healthcare system, recognizing that a lot of care can be

provided in the community. Even though maybe that's not in our direct interest as a place that has fought for decent-paying jobs in hospitals, we believe it's the right thing to do. But if you do that wrong and if you don't make sure that you have the infrastructure there, you're not going to have emergency care, you're not going to have the institutions that people depend on.

So again, we think the Governor's budget is a good start. We think it's right to recapture some of the dollars that large for-profit corporations are gaining from the tax cuts and from the postponement of the ACA insurance taxes, and we think it's right to recapture some of the proceeds from the sale of a company that was really created with public investment, and to use that to stabilize our healthcare system -- both, again, to deal with the effects of these cuts, which are real, and also to raise rates for Medicaid-dependent institutions who are really struggling and the cracks are starting to show.

Just on that last point, you know, I know there was some testimony from the commissioner and from the Medicaid director earlier about nursing homes. Our experience is nursing homes are not in good shape. And again, we hear from our members all the time how terrible they feel about trying to take care of people without the appropriate staff or the appropriate resources to do that. In many cases it's because the nursing homes are driving down the costs of operating those homes in a way that is not safe for residents and certainly not good for workers. So we don't think the condition is good and do think an investment there is certainly warranted.

Last piece, I know you're going to be hearing from the Home Care Association on some of the long-term-care proposals. We think that this budget proposal from the Executive really kind of recognizes the limitations of the partially capitated managed-care plans. We always thought that that could be something that was on the way

station to a fully capitated plan where you could capture Medicare and reinvest that to take care of people.

If you're only capping Medicaid costs, you're really just managing utilization or price. It has not been good for quality in many cases, and we think it's right to recognize that. By eliminating coverage for folks who are long-term nursing home residents, paying that fee for service -- the same thing with low utilizers -- you're not cutting services, you're just changing the way they're paid in a way that we think makes sense.

Very last point on long-term care. There is a proposal to limit the number of licensed home care agencies that are contracted for by managed-care plans. We think that's the right proposal. We think there's a lot of implementation questions, the number might be wrong, but we need to strengthen that delivery system, we need to have companies and providers that can really provide high-quality care. We can't do that

with 1600 companies, many of whom are kind of in a Wild West of obeying or not obeying rules. And so we think that proposal is a very strong start, and we would support it.

CHAIRWOMAN YOUNG: Questions?

Well, thank you so much.

CHAIRWOMAN WEINSTEIN: Thank you.

CHAIRWOMAN YOUNG: The next speaker is President Joanne Cunningham from the Home Care Association of New York State.

Welcome. So we have five minutes on the clock, and if you could summarize, that'd be great. Thank you.

MS. CUNNINGHAM: Thank you very much.

This has been quite a marathon session, so out of respect for your going on your eighth hour of hearing testimony and asking great questions, and also out of respect for all my colleagues who are still in the room waiting to speak with you, I'm going to keep my testimony short.

We gave you a copy of my written comments, you can all read them, they're very comprehensive. We also gave you two other

documents: One is a financial condition report that articulates what the fiscal status is of the home- and community-based care sector across New York State. This is the ninth year in a row we have done this, and there are some troubling trends with respect to the financial standing of the home care system in New York.

Thank you again for the opportunity to speak with you today. Again, I'm Joanne Cunningham, I'm the president and CEO of the Home Care Association of New York State. We represent home- and community-based providers, certified agencies, licensed home care service agencies, hospices, as well as managed long-term-care plans and what is left of the long-term home health care program providers all across the state, from the tip of Long Island to the Adirondacks to out west in Cattaraugus County and the Finger Lakes and all across the state.

Our providers offer services to keep patients in their home and provide care in the home. These services are uniquely

matched to meet the patient's individual needs as well as the physician's care plan. Whether it's chronic care management, assistance with activities of daily living, medication management, wound care post-acute therapies, maternal newborn care, nutrition, infection control, public-health-oriented interventions, palliative and end-of-life care, and a range of additional services.

So as you can see, the care that is provided by the home- and community-based-care sector is very comprehensive. It includes public health primary care as well as post-acute care and long-term care.

Annually about 400,000 patients receive home care services in New York State, and all of these services are aiming to support the entire healthcare system as well as the state's overarching healthcare cost-containment goals, and they do this by preventing hospitalizations, by keeping patients out of hospitals as well as doctor's offices by providing an alternative to nursing home care, and by improving the

health and safety of frail elderly citizens.

Today I'm going to just point to a couple of highlights in our financial condition report, because I think it's really helpful to understand what the fiscal climate is for the home- and community-based sector. Mr. Raske spoke about the troubles with reliance on Medicare and Medicaid as payers and, you know, the cost-shifting that hospitals and other providers do to commercial payers. Well, in the home care sector we don't have the opportunity to have commercial payers offset some of the underpayment of Medicare and Medicaid, and as a result what we have seen over the past decade, certainly, since we have been collecting data and evaluating cost reports for both home care agencies as well as managed long-term-care plans, is that this is a system that is declining in terms of their fiscal standing.

Approximately 62 percent of all MLTC plans had negative premium incomes in 2016. That was up from 42 percent in 2012, just

four years earlier. Fifty-two percent of all MLTCs had medical expense ratios over 90 percent in 2016, compared to 42 percent of MLTCs in 2015.

And that indicates that their PMPM revenues from the state are not sufficient to meet the overall plan medical expenses to pay their contractors, the certified home health agencies, the licensed home care agencies and other network providers.

I just want to highlight a couple of things. One is you've heard a lot about the LHCSA limit. We absolutely are opposed to the LHCSA limit. You heard a lot about the reasons why -- it's anticompetitive, it's anti-consumer choice. But consider this. In some communities, the LHCSA limit is precluding -- or is offering consumers a home health aide that speaks Cantonese or speaks Russian, and that's really important to match those. And that's one of the reasons why some of those LHCSAs have contracts with certain plans. They have a certain language proficiency, and that's particularly evident

in New York City.

Just categorically, some of those MLTC changes are extremely troubling and will cause significant fiscal pressure and harm to the home care system. You've talked about them: the eligibility requirement, the other cuts that are imposed on the MLTC plans as well.

And then finally, I just want to -- no one has really talked about workforce. We have a lot of work to do on workforce. There was an article in the Ithaca newspaper today about the struggle with retaining and attracting workers in the home care sector -- not just home health aides, but RNs, clinical staff as well.

I thank you so much for your attention today, and we'd welcome any questions.

CHAIRWOMAN YOUNG: I think we're all set, but thank you so much.

SENATOR KRUEGER: Thank you.

MS. CUNNINGHAM: Thank you.

CHAIRWOMAN YOUNG: Our next speaker is Claudia Hammar, president of the New York

State Association of Health Care Providers.

We look forward to you summarizing your testimony.

MS. HAMMAR: Absolutely. Thank you for your time today. I appreciate that, and I will keep my remarks brief as well. You have our written testimony there.

My name is Claudia Hammar, and I'm president of the New York State Association of Health Care Providers. We are a trade association that represents approximately 350 offices of licensed home care services agencies, certified home health agencies, and health-related organizations throughout the state.

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 Program as well. Most of these services are reimbursed in the state's Medicaid program, with more than 180,000 people currently

enrolled. The long-term population is rapidly growing as part of New York State's Medicaid program.

Over the past few years, home care providers have faced unprecedented challenges with mounting labor costs, a rapidly changing regulator environment, and reimbursements that do not begin to cover an agency's real cost. HCP believes that some of the proposals in the Executive Budget will jeopardize New York's home healthcare system and put patients that it serves in jeopardy.

In the interests of time, I would just like to focus on a couple of key issues.

First, the minimum wage and its implementation. This year, the Governor funds minimum wage for direct care workers at approximately $703 million. Home care providers have had tremendous difficulty receiving minimum wage funding for Medicaid managed-care plans, and stronger mechanisms are needed to ensure these funds are actually distributed in a timely manner to home care providers to support their workforce.

For the second year in a row, the process of getting minimum wage funds from plans to providers by the December 31st effective date is inherently broken, and in many cases providers and plans did not meet that date. Some plans were issuing contract amendments the week between Christmas and New Year's, right up to the deadline, making it nearly impossible for home care agencies to ask questions, get information from plans, or negotiate rates in time for their implementation. Many home care providers had no contract amendments at all from plans. But despite the controversy and uncertainty, home care agencies still needed to pay their workers the increased minimum wage by December 31st.

Given this problematic situation, HCP is encouraging the Legislature to implement a process by which plans must distribute funds to providers 90 days prior to the effective date in order to avoid late contracts.

We also urge that insurers provide the funds in an amount that supplements any

existing contracts. HCP also urges the Legislature to disallow risk adjustments on all statutory wage obligations on managed-care providers to ensure that the plans distribute the full amount given by the state for the intended purpose of paying the workers. Without adequate rates, home care agencies will have no choice but to reduce services, negatively impacting consumers' access to care and the workers who provide these services, all at a time when the demand for these services is increasing.

Secondly, I'd like to comment on the Executive Budget proposal limiting the number of LHCSA contracts a managed long-term care plan can have to 10. Given this proposal, and recent statements by the state Medicaid director, it is no secret that the state is looking to reduce the number of licensed agencies.

However, this proposal would create significant access-to-care issues for tens of thousands of New Yorkers who receive essential home care services from licensed

agencies. This is included as an administrative proposal, and is not included in the Health/Mental Hygiene Article VII language.

However, there is a savings of $13.71 million to the state for the fiscal year. At this time industry stakeholders, including HCP, are unaware of the methodology by which this savings is calculated. And in terms of DOH's position that this proposal would increase quality, we fail to see how this is possible with a significantly reduced number of licensed agencies handling a growing number of clients. Simply put, there is no reasonable justification for the limitation of LHCSA/MLTC contracts to 10.

This proposal would provide additional leverage to MLTC plans over home care providers in negotiations where providers are already significantly disadvantaged. Moreover, plans hold the majority of the power during plan/provider negotiations. If an MLTC does not want a contract with a particular agency, they simply do not have

to. Therefore, there is no need to place an arbitrary statutory number on planned provider contracts.

In addition, the timing of this proposal is extremely problematic. It would go into effect on October 1, leaving little time to shift provider/plan contracts and little time to place tens of thousands of consumers into a different network if necessary. By restricting the number of LHCSAs and MLTCs plans can contract with, elderly and disabled Medicaid enrollees would be forced into a severely limited home care provider network that would significantly constrict consumer choice.

Finally, HCP believes that this discussion about licensed agencies needs to happen outside of the budget process, something stakeholders thought was going to be discussed further through the regulation modernization initiative process. In order to evaluate LHCSAs where there may be too many, where there aren't enough, where perhaps there are bad actors, the state needs

to look at Article 36 of the Public Health Law which governs these agencies in order to have the appropriate discussion about the viability of an industry.

HCP urges the Legislature to reject this proposal outright, not only because it would lead to the closure of many home care businesses, but it would severely limit access to essential and specialized care for consumers, including those in niche communities.

Thank you. I'd be happy to take any questions.

CHAIRWOMAN YOUNG: Thank you very much.

SENATOR KRUEGER: Thank you.

CHAIRWOMAN YOUNG: So our next speaker is Bishop Edward Scharfenberger from the Archdiocese of New York, and then we'll go to NYSHFA after that. The bishop is joined by Jenn Hyde, Catholic Charities Tri-County Services.

So welcome to both of you.

BISHOP SCHARFENBERGER: Thank you very

much. And good evening, Chairpersons and other distinguished legislators.

And I appreciate the opportunity to be here tonight. As bishop of the Diocese of Albany -- I am actually not the Archdiocese. I've got Brooklyn roots, you can probably tell by my accent, but I'm the Diocese of Albany -- but I'm humbled every day with the honor and privilege serving as the spiritual leader and advisor to New Yorkers of every social-economic level, background, birthplace, and walk of life. I am energized by the stories I hear from them and so many others, and of how they've overcome challenges, the selfless acts they do for others and the positive outlook they maintain in the midst of some of the most heartbreaking tragedies. In your roles as elected officials, I'm sure that you too are inspired by the life stories of your constituents who overcome seemingly insurmountable odds to improve their lives and those around them.

But I am here today as a governing

member of Fidelis Care, the New York State Catholic Health Plan, in connection with the sale of the assets of Fidelis Care. The transaction has created an historic opportunity for a new foundation to help transform the lives of New York's poor, neediest, and most vulnerable populations.

It is an opportunity to provide billions of dollars to improve the health and welfare of individuals and families across New York State, from each urban neighborhood to the most rural corners of the state -- billions of dollars that will help New Yorkers remove the shackles of poverty and enable them to achieve the opportunities most of us in this room enjoy. The funds will expand access to healthcare, provide homecare to our rural elderly, improve immigrant health, feed the hungry, raise childhood literacy levels, facilitate supportive housing, quell the opioid epidemic, and further countless other goals shared by the Catholic Church and the State of New York.

Yet New York State may miss this opportunity. The state's financial plan, as presented in the Executive Budget, relies on the state seizing virtually all of these funds that are otherwise intended for New York's poor. We have been advised that such a taking is illegal and unconstitutional. That this unprecedented confiscation is directed at a faith-based institution, and seeks to disrupt our mission of caring for the poor of every race, creed, color or disability, is even more alarming. The state's announced action would of course make it impossible for us to move forward with this transaction, which would create a tragic loss of an unexpected resource for New York.

Now, common sense and logic show that a charitable foundation that will permanently assist New York's poor will provide a greater public benefit than catering to special interests with a one-shot budget solution. My sincere prayer is that wisdom and common sense will ultimately prevail and will

prevent this from happening.

So with that fervent hope, please let me discuss further the transaction and its importance to our state.

As you may know, Fidelis Care began operating in 1993 as the Catholic Health Services Plan of Brooklyn and Queens. In 1997, the eight bishops of the Catholic Dioceses of New York, led by John Cardinal O'Connor, expanded Fidelis Care across the state to improve the health and wellness of underserved New Yorkers. It has become a model for managed care in the United States.

It is no surprise to those of you in this room that the healthcare financing and delivery system is rapidly changing due to a variety of factors, including federal and state regulation and funding as well as technological innovations. Recently it became clear to my fellow bishops and me that we can best serve those most in need by exiting the health insurance business.

We decided that in order to elevate Fidelis Care to the next level of service, it

was in the best interests of Fidelis Care's insureds to find a better capitalized and a more technologically advanced national organization to carry on Fidelis Care's commitment to New York State. We identified and secured the best partner for this undertaking in the Centene Corporation, a national health plan which has the financial, technical and medical expertise to successfully operate and manage Fidelis Care in New York.

We believe that Fidelis Care members and employees will benefit from enhanced access to capital markets, ensuring greater resources to provide new, state-of-the-art technology, and a transfusion of industry best practices.

Centene has promised us and the State of New York that New Yorkers in all 62 counties will continue to have the same wide access to quality health insurance, compassionate customer support, and the information and resources they need to make informed health decisions. Centene,

recognizing the strength and value of Fidelis Care's New York State workforce, will retain all current employees to ensure a seamless transition. The company already operates in over 25 states and brings deep industry knowledge to Fidelis Care that very few other firms can offer.

As we pass the baton to a sophisticated national organization with resources which can effectively assist our state's Medicaid population, Fidelis Care will take those proceeds and transform them into a major healthcare foundation to provide aid to the most vulnerable New Yorkers to cover the things they need which Medicaid may not currently provide.

As a grant-making foundation, Fidelis can more effectively focus its resources and efforts on addressing greater access to quality health care for all New Yorkers, addressing social determinants of health, such as housing, employment, nutrition, mental health and social support. There has never been such an undertaking in New York

State. There is no precedent. The foundation, though born of our faith's need and obligation to provide charity, will help all needy New Yorkers of every color and every creed, consistent with our Catholic values.

The foundation will be the largest foundation focused totally on New Yorkers and will advance and accelerate Fidelis Care's founding mission to provide for the health and well being of underserved New Yorkers of every religion and walk of life. The foundation will be meticulously managed and adhere to the strictest governance structure under the law as an effective and transparent philanthropic organization.

The proceeds from the transaction will allow Fidelis to make up to $200 million in grants every year specifically to charitable programs serving the needs of vulnerable populations. These funds will help ensure that New York's poor, disadvantaged, and infirm are getting the services, opportunities and support they need to live

healthy, dignified lives so that living the dream becomes a reality for so many whose days seem like nightmares.

CHAIRWOMAN YOUNG: Your Excellency -- Your Excellency, we do have your testimony. If you could wrap it up and -- I know that Catholic Charities --

BISHOP SCHARFENBERGER: Yes. The point I would like to make is that this is a foundation that will exist in perpetuity, and that this is more than just addressing what is a temporary budgetary -- albeit important -- this is unprecedented. This will give us an opportunity to reach many more people, building on the wonderful history of the foundation itself, of Fidelis Care, and will enable us to reach so many people who we already have relationships -- as you well know, between the state and many of our agencies, Catholic Charities in particular -- people who will come to us in order to receive the services that we're able to deliver.

And of course, the other point -- and

I'd like to close -- in closing, I respectfully request that we work together to ensure that our foundation can begin to help the poorest and neediest among us as. Let us make sure together that this unprecedented opportunity is not wasted.

CHAIRWOMAN YOUNG: Thank you.

BISHOP SCHARFENBERGER: And I'd now like to introduce Jenn Hyde, our executive director of Tri-County Services, an agency that coordinates an array of essential basic needs and youth services in Albany.

CHAIRWOMAN YOUNG: We do have your testimony, and if you could please summarize it, that would be helpful.

MS. HYDE: I will. I'll be very brief.

The Fidelis Foundation would provide the critical funding that we need to expand our services. I think that we can all agree that the challenges in the community are very real. We see folks every day who struggle with: Where will my next meal come from? Should I pick up my medicine at the pharmacy

or should I pay my heating bill? My children need school clothes, they're growing so quickly, how can I afford it?

This funding and this support is essential to meeting folks where they truly are at. We have a moral duty to make sure that we're not leaving anyone behind.

I appreciate your time in reading the rest of my testimony.

CHAIRWOMAN YOUNG: Thank you very much. Thank you.

Our next speaker is -- actually, we have two -- President and CEO Stephen Hanse, New York State Health Facilities Association, and executive director, Foundation for Quality Care, Nancy Leveille.

Welcome. Again, if everyone could try to adhere to the five-minute rule, summarize your testimony, we do have it on file.

MR. HANSE: Absolutely.

CHAIRWOMAN YOUNG: Thank you.

MR. HANSE: Good evening. And my testimony was prepared for "good afternoon."

My name is Stephen Hanse, and I have

the privilege of serving as president and CEO of the New York State Health Facilities Association and the New York State Center for Assisted Living, a statewide association whose members and 60,000 employees provide essential long-term care services to over 50,000 elderly, frail, and physically challenged men, women, and children and over 400 skilled nursing and assisted living facilities throughout the state.

Joining me today is Nancy Leveille. She serves as executive director for the Foundation of Quality Care, and she has over 30 years' experience as a practicing clinician in both acute and long-term-care settings.

It has been said that to care for those who once cared for us is one of life's greatest honors. And it is with this sentiment in mind that I would like to provide you first with a brief overview of the current constraints affecting New York's skilled nursing providers.

And while there are many proposals

affecting skilled nursing providers in the proposed 2018-2019 Executive Budget which we address in our submitted testimony, Nancy and I will highlight briefly five specific issues contained in the Executive Budget.

The constraints facing nursing homes in New York are significant. Over the past 11 years, funding cuts to New York State's long-term-care providers have exceeded nearly $1.9 billion. At $61 per patient per day, New York unfortunately leads the nation with the largest shortfall between the rate of Medicaid payment and actual cost in providing resident care in nursing homes.

Additionally, as was previously stated, it's been over 10 years since the state's skilled nursing providers have received a trend factor for inflation, and we continue to endure ever-growing operational expenses to meet the requirements of New York's expanded minimum wage, paid family leave, health insurance increases, and ever-rising food and utility costs -- costs which, unlike almost all other industries,

cannot be passed through to consumers.

Turning to the first issue we'd like to discuss, NYSHFA supports the Executive Budget proposal of the transition, for nursing home residents, from managed long-term-care enrollment to, after six months of continuous nursing home care, fee-for-service Medicaid. This proposal would be effective April 1st of 2018 and is anticipated to save the state $147 million in the 2018-2019 fiscal year and $245 million in the following fiscal year.

NYSHFA supports this proposal and further recommends the threshold period be moved from the proposed six-month period to a three-month period. Moving to three months is in line with the 100-day federal Medicare nursing home stay requirements as well as nursing home patient-care plan assessment requirements, and will provide residents a more timely opportunity to return to the community.

Moreover, by moving to three months, the state will save additional monies, monies

which we respectfully request that the Legislature utilize to offset the Executive's arbitrary cuts to skilled nursing providers, cuts in case mix, capital, and penalties imposed upon the state's most struggling providers.

MS. LEVEILLE: We know that there's a concern about residents needing managed-care organizations to discharge them back to home, and they worry about their homes being displaced. But those elders that come into the nursing home, at the 100-day mark they're still able to use their Medicare up to that point if they're eligible. But these are the more complex residents that are elderly, have comorbidities, that we would continue to reassess and plan for either long-term care or to continue to plan for their discharge. We have intervals of six, nine, 12 months where we have successfully been able to discharge them back to home or back to less restrictive entities like assisted living or adult homes.

So we know there is concern about

that, but this is something the nursing homes continue to do in terms of discharge planning for the elderly. But they need more time.

MR. HANSE: The second issue included in the Executive Budget we would like to highlight is an administrative proposal to cut the case-mix payments to skilled nursing provider Medicaid rates by $15 million annually, for a $7.5 million state share.

By way of background, the case-mix index is a direct reflection of a resident's acuity in a nursing home. New York State as well as 34 other states utilize the case-mix system for reimbursing care to providers. Nursing homes throughout New York are expanding their clinical skill set and caring for residents with more comorbidities and medical acuity than ever before. As such, hospitals are able to discharge individuals in a more timely manner, knowing that skilled nursing providers can deliver advanced care to their patients.

MS. LEVEILLE: I'm going back to 2006 to 2009. Case-mix payments were frozen at

the state level as we changed from the old PRI instrument to the newer minimum dataset. At that time, because payment was frozen, the nursing homes had to really kind of cut the medically complex residents that they were taking because of the dollars less -- you know, the underpayment in Medicaid at that time, even, to care for residents.

With the change now to the minimum dataset and also the major shift to those med/surge residents coming into the nursing homes, we now have a much more accurate tool. And this is one of the reasons why there's been an increase in costs and reimbursement, because it's more accurately assessing the residents.

But in addition, the shift to the more medically complex is also the other reason why the costs have gone up in this area. But it's really just reimbursing for the care that's been provided. If this gets cut, if this arbitrary cut gets made, we may go back to that where the nursing homes are not going to be able to afford to take those

higher-level med-surge residents. That can cause a real shift in terms of backup to the hospitals, increasing their length of stay in the hospitals, and maybe never even moving, which would cause a major logjam.

So the Executive's proposed cut creates a disincentive to admit the neediest and highest-cost-care residents as a consequence of the state's insufficient reimbursement for the provision of care. So recognizing that, in 2014 the Legislature rejected the Executive's Budget proposal just for that main fact.

So NYSHFA is respectfully requesting the Legislature to once again reject the Executive's efforts to cut patient care reimbursement.

MR. HANSE: All right. To summarize our final issues, we oppose the capital cut. The Executive Budget proposal arbitrarily cuts nursing home capital rate reimbursement by 1 percent. Our providers have made decisions based on previously approved determinations of the Department of Health.

We let -- Nancy touched on this real quick -- we would also -- the 1 percent restoration, if you recall the 2014-2015 enacted budget, the Legislature approved the restoration of the 2 percent across-the-board cut. As was mentioned earlier by the Medicaid director -- actually, this was not mentioned -- 1 percent of that 2 percent was used for a one-time settlement with nursing homes. It was not included in the rates, it did not go to nursing home rates. The state has yet to return these funds to nursing homes. We respectfully request that the state share of these funds be paid.

And lastly, the 2 percent --

CHAIRWOMAN YOUNG: Okay, if you could please wrap it up, because we have a lot of people to testify.

MR. HANSE: Sure. Nancy just will touch on the 2 percent cut that is --

MS. LEVEILLE: The 2 percent quality cut, in addition to the Nursing Home Quality Initiative, which already takes $60 million out of the Medicaid fund -- so the

$60 million is a cost-neutral Nursing Home Quality Initiative already. It's set up in five quintiles. So Quintiles 4 and 5 pay that $60 million to Quintiles 1 and 2 already. That's the basic plan.

This additional 2 percent cut will add another $20 million to those Quintiles 4 and 5 to pay out. So it can be $80 million to about 100 nursing homes across the state.

These nursing homes -- the other part of this is in the Nursing Home Quality Program, there's always going to be five quintiles. In 2017, the department just sent out a report that showed the improvement the pools had by moving up in their quality measures. We have to reset targets because they're improving. So it doesn't mean those in 4 and 5 are always the poorest performers, it's just that you've got to have five quintiles to make it work. So that additional $20 million could be financially disastrous to some of these nursing homes.

MR. HANSE: Again, I'd just like to leave you on the fee-for-service proposal.

Again, we strongly support moving from six months to three months. That would ensure folks would be able to move to the community at a faster rate, it's in line with the federal Medicare 100-day requirements.

And thank you very much for your time.

CHAIRWOMAN YOUNG: Thank you.

MS. LEVEILLE: Thank you.

SENATOR KRUEGER: Thank you.

CHAIRWOMAN YOUNG: Our next speaker is Ami Schnauber, vice president of --

ASSEMBLYMAN RAIA: I have a question for them.

CHAIRWOMAN YOUNG: Oh, I'm sorry.

ASSEMBLYMAN RAIA: Thank you.

Very quickly, I heard "trend factor" mentioned a whole lot here today, but when I quizzed Mr. Helgerson on it, he told me they don't use trend factors any more. Do you know what he was talking about?

MR. HANSE: No, you're correct. As Helen Schaub mentioned, as Ken Raske mentioned prior, it's been over 10 years since Medicaid providers have been allocated

a trend factor for inflation in New York State.

We have not received that, all the while facing increasing costs for care of patients and all the ancillary issues that we deal with -- utilities, everything goes up. And again, as I mentioned, unlike almost all other industries, we are unable to pass that cost through to our residents as Medicaid providers.

ASSEMBLYMAN RAIA: Thank you.

MR. HANSE: Thank you.

Any other questions? Thank you.

CHAIRWOMAN YOUNG: Thank you.

Our next speaker is Ami Schnauber, vice president of advocacy and public policy for LeadingAge New York.

I'd like to remind the speakers, we've gotten your testimony in advance. Speakers are supposed to adhere to a five-minute limit. So if you could please summarize, that would be really helpful, because we have many, many, many other people waiting to speak.

Hi, Ami.

MS. SCHNAUBER: Hi. Thank you so much.

My name is Ami Schnauber. I'm with LeadingAge New York. We represent over 400 not-for-profit aging services providers across the state, from independent senior housing, assisted living, managed long-term care, and nursing homes.

I'm going to just focus on a few things that others have not. I think Jason Helgerson mentioned the quandary we're in, which is that we have an aging population. In the next 10 years, 20 percent of New York's population is going to be over age 65. At the same time, we have a diminishing workforce who's going to be able to take care of them, and New York ranks above the national average for diabetes. We have sort of a perfect storm coming -- and unfortunately, once again, we have a state budget that cuts and disinvests in long-term care instead of putting money in.

If you look at page 1, you'll see that

$407 million are being taken out of managed long-term care and nursing homes and other aging-services providers at a time that we really need to be investing.

On page 2, you can see that of the transformation grants that were provided last year, less than 5 percent went to long-term-care providers. And on page 3, the pie chart will tell you that while there -- we were pleased to see the Governor dedicate funding to the Assisted Living Program in nursing homes, we would suggest that it needs to be far greater than that. Long-term care makes up 30 percent of the Medicaid spend, and we would suggest that the capital should be at that amount as well. So we're asking for $150 million.

The other thing we're gravely concerned about is the $325 million that is being cut from the managed long-term-care providers. Many people mentioned the LHCSA contract limit -- we're really concerned about that. We think, instead, the PHHPC should stop approving additional LHCSAs and

perhaps the state should look at uniform cost reports to get a real sense of what LHCSAs are out there and what their costs look like.

We're also very concerned about the marketing and referral ban. Unfortunately, a number of these $325 million cuts in managed long-term care are administrative, and there don't seem to be real program changes, and it really is just pushing down the rate for managed long-term-care plans, and we really encourage you to reverse some of those cuts.

As NYSHFA said before, we're concerned about the $42.6 million that's being cut from nursing homes. Chief among them are the cap on case-mix rate increases and reducing capital rates.

We are also very concerned about the opioid surcharge, particularly as it relates to hospice. Our hospice -- 2 cents per milligram is going to have a really big impact on hospice, and they suggest that anywhere from 25 to 45 percent of their drug costs are going to increase. And it's just simply unsustainable.

We are not doing a good job in hospice in this state. We need to do better. We have a recommendation where we would like you to help us get people who live in the ALP access to hospice. Right now they cannot access hospice, and we think that's wrong. We think that we need to make sure that if we're doing an ALP expansion, which we support, there ought to be a need methodology that has it reasonably placed throughout the state, and we would like to provide you with some language on that.

And then we've been looking for -- we got some historic funding in last year's budget, $125 million for independent senior housing. We know that housing is a social determinant of health for seniors. It often allows people to return to the community when they couldn't have returned to their own home. We really need a service advisor program that would accompany that, would provide for some wellness programs, much like the HUD offers through their service coordinator. We would like to see that in

independent senior housing where they do some wellness, make sure that they have access to food, affordable housing, and we're asking for $10 million over the next five years to help facilitate that.

And workforce investment. We already have service gaps in this state, and if we don't start doing something about workforce, we're going to be in a real difficult spot with our seniors. We're a little disconcerted that the MLTC workforce money, which was $250 million last year, is suddenly $150 million. We don't know where the 100 went, and we're concerned that that money is only going to go to home care providers when that was never the intent.

So we think that we have to take a systemic approach to long-term care to start meeting this growing demand.

Thank you.

CHAIRWOMAN YOUNG: Any questions?

Thank you.

MS. SCHNAUBER: I did that in less than five minutes.

CHAIRWOMAN YOUNG: Yes, you did. Very good.

Our next speaker is President and CEO Eric Linzer, from the New York Health Plan Association.

Welcome.

MR. LINZER: Hello. Thank you for the opportunity to testify today. With me today is Kathy Preston, HPA's vice president of government affairs. And in the interests of time, I'm going to try and be as brief as possible.

We're obviously concerned about a number of provisions in the proposed Executive Budget. First among them is the proposed 14 percent tax on for-profit health plans. You know, our main concerns on this is that, first, it unfairly affects one specific industry when the changes in corporate tax reductions affect many, many more companies than just health plans.

Second, taxes on health insurance are already too high in New York. We collect nearly $5 billion in taxes, fees, and

assessments, making health insurance taxes the third-largest revenue generator behind sales and income taxes. If we're going to be looking at additional fees and costs, we ought actually to be thinking about how to better utilize that $5 billion in taxes.

Third, this tax is unnecessary because the federal cuts that are expected to be used to fund this aren't materializing. You heard DOH say earlier today that there is the potential that this money could get reallocated and reappropriated. That's not a good thing for employers and consumers.

And at the end of the day, if we're going to create a piggybank to fund against potential costs in the future, then we really need to be thinking about shared responsibility. And as you heard some of the hospitals talk earlier about this need for additional funding, then there should be an element of sharing in that responsibility, and we may want to look at certain things such as the indigent care formula and perhaps asking hospitals to provide greater

transparency around their margins.

Second, we're also opposed to the proposal that would reduce Medicaid rates for nonprofit health plans if their reserve levels are above the statutory minimum. As you heard earlier today, there is concern with this proposal, as the bare-bones minimum represents exactly the amount needed in order to maintain stability in the marketplace and avoid panic.

Going below that threshold by pushing down on Medicaid rates, we think, has the potential to have a very destabilizing impact on the marketplace, and you need look no further than the recent example of Health Republic and the liquidation that came about from that. It created a great deal of confusion for consumers and their providers who, to this day, still haven't been paid.

You know, reserves are there for a reason, to protect against the unanticipated cost, whether it's a bad flu season like the one we're having this year or it's the cost

of new drugs to marketplace like Sovaldi. Reducing reserves as a way to place a sort of -- balance the budget or fill in the gaps in the budget is destabilizing, and it doesn't understand the reason why reserves are there.

And then finally, we're opposed to the creation of the Healthcare Shortfall Fund from the proceeds of nonprofit health plans to convert into for-profits, and we think this creates a very bad precedent for the marketplace and essentially allows the states to seize the proceeds from a private transaction, which would make New York a less attractive place to do business and, more importantly, does nothing to address underlying healthcare costs.

And with that, I'll turn it over to Kathy to talk a little bit about some of the other provisions in the Governor's budget that we have concerns about.

MS. PRESTON: Good evening. We've talked a lot today about MLTCs, so I'm going to throw in one more that we haven't talked

about today. We support the state's efforts to get control over the growth of the MLTC program. We think there's probably a lot of better ways to do that. What we don't support are proposals that are just cuts masquerading as reforms. That would include reducing the MLTC administrative reimbursement by $40 million, with the vague promise of future regulatory relief. We're pretty sure the cut's going to come, but the regulatory relief won't.

We do support the ban on marketing for certain long-term-care providers; we think it should be implemented immediately instead of waiting until October.

And we also agree that it is critical to the Health Department to begin collecting detailed cost reports from the licensed home care agencies and the fiscal intermediaries in the consumer-directed program. We don't get them, and now there's $700 million in minimum wage and other wage-related funding going out the door this year, and it's time to start understanding more clearly where all

of that money is going.

Health Homes, nobody's mentioned Health Homes today. There's a two-year All Funds appropriation in the Health Department budget of $170 million. The actual current year spending is anticipated to be $512 million. What little performance data is available has been questionable at best. And it was an interesting experiment when the federal government was paying 90 percent of the reimbursement, but it has failed to prove its value now that the state is footing 50 percent of the bill. So we urge the Legislature to reject the planned specific Health Home enrollment targets and penalties on plans.

And then finally, on program integrity, we think that the OMIG provisions in this budget proposal are a little too onerous, and we would urge you to oppose the fines and clarify the referral requirement. We are more than happy to work with the OMIG, but they were created when the Medicaid program was largely fee-for-service. And a

lot of their work is now duplicative to what the SIUs within the plans are doing, and we think there's a better way to do it.

Thank you.

CHAIRWOMAN YOUNG: Thank you.

The next speaker is President and CEO Rose Duhan, Community Health Care Association of New York State.

Welcome.

MS. DUHAN: Good afternoon -- no, good evening, Chairperson Weinstein, Chairperson Young, Chairperson Hannon. Thank you for the opportunity to comment.

I'm Rose Duhan, I'm the CEO of the Community Health Care Association of New York State. We represent federally qualified health centers, 68 FQHCs in New York State. We have over 750 sites where we deliver care. FQHCs provide primary care, the day-to-day healthcare that we all need, with a focus on patient education, prevention, and treatment of chronic conditions. And as we know, primary care is fundamental to the state's transformation of the healthcare system and

the reduction of overutilization of hospitals.

There's four points in the budget that I want to touch on. Before I do, I will refer to the facts about FQHCs that are in the written testimony. We serve over 2.2 million New Yorkers -- that's one out of every nine New Yorkers get healthcare at an FQHC. Over 50 percent of our population is on Medicaid, and the rate of uninsured that we see is three times the state average. So even though there has been a tremendous increase in insurance coverage throughout New York State, we are still seeing a larger proportion of uninsured patients at community health centers.

The first item that I want to comment on in the budget is the Safety Net Pool. We were very pleased to see that the Governor has continued the $54.4 million of funding for the Safety Net Pool that was authorized last year by the Governor and the Legislature. That funding is critical to serving the uninsured, which I just referred

to; as I mentioned, it's much higher at FQHCs. At some of our health centers, as much as 50 percent of the population is uninsured, especially at health centers that serve specifically the homeless population. So that Safety Net Pool is really critical to making sure that everybody has access to care.

Federally qualified health centers are required to see everybody who comes through their door, regardless of their insurance status or their ability to pay, and we are proud to do so. And that funding, the safety-net funding, allows us to do so.

The second item I would like to highlight, as Senator Krueger mentioned, is the reduction to the patient-centered medical home. We're very concerned about that. As Senator Krueger said, we're somewhat the victims of our own success. Over 90 percent of FQHCs have achieved PCMH certification -- we're very proud to do so, that was one of the goals of the DSRIP program, and we have accomplished that. Those incentive patients,

those incentive payments are really crucial to allowing the health centers to achieve those high-quality levels and to sustain the quality of that program and provide a lot of the care management and wraparound services that help enhance the primary care.

So we are very concerned about that cut and urge the Legislature to reject that cut.

The third item I will mention is the capital funding that is in the budget. We are very pleased to see that there's $60 million set aside for community-based providers. However, we would urge that the proportion of funding for community-based providers remains proportional, continues at the same proportion of the investment that was made last year, which was 15 percent of the total funding was available for community-based providers.

So notwithstanding the $20 million that's set aside for ALP, we would like to see the same level investment, $60 million, preserved for community-based providers,

which includes community health centers, behavioral health providers, home care, and substance abuse disorder services.

We were also pleased to see that the capital funding included authorization for utilization of capital to fund telehealth. As was mentioned earlier, telehealth is really critical to insuring access, especially in rural areas. And really a lot of health centers have been on the forefront of using telehealth to -- especially in terms of ensuring access to speciality providers and behavioral healthcare providers.

We are a little bit concerned that the language that is in the budget specifically mentions acute care, post-acute care, and long-term care. We understand that it is not the Executive's intention to exclude primary care. We think there should be a language clarification to make that clear so that primary care can access the capital funding for telehealth purposes.

The final item I will mention, I know Senator Hannon is very fond of the RMI, and

we are pleased to see that recommendations from the RMI were included in the budget. Two of the recommendations that came out of the workgroups that we're especially supportive of are expanding the definition of originating site for telehealth and the lifting of caps on the limits of behavioral health services that can be provided in the primary care setting. We think that being able to expand those services will greatly facilitate the integration of primary care and behavioral health.

Thank you.

CHAIRWOMAN WEINSTEIN: Assemblyman Cahill.

ASSEMBLYMAN CAHILL: Thank you. I'll be very brief.

I don't know if you were here earlier when Dr. Zucker was testifying that the legalization of corporate, shareholder-owned Minute Clinics would help primary care doctors do their job better. How do you think that would help you help your primary care facilities do their job better?

MS. DUHAN: I think Minute Clinics are really a convenience for consumers, and I think that the health care system really has to adapt for what consumers need and want.

We think that a lot of the language that's in the budget that ensures that there is connection to primary care, to more robust primary care, is really important so that when people are going to Minute Clinics they can make sure that there is -- that they do have a regular source of primary care so that there's those connections. Those pieces are really important to make sure that people can have -- especially individuals with chronic conditions, and who need ongoing treatment, that those treatments -- that that treatment is provided in the appropriate setting.

ASSEMBLYMAN CAHILL: Well, will it let your doctors see patients longer?

MS. DUHAN: Will it make our -- let our patients --

ASSEMBLYMAN CAHILL: -- doctors see their patients longer?

MS. DUHAN: I can't speak to

Dr. Zucker's comments. I mean, I think there are some things that can be treated quickly at the clinics, at the retail clinics. And that that's something, as I said, that's happening now. So I think it's a matter of how do we make sure that there's a robust connection with the primary care.

ASSEMBLYMAN CAHILL: Okay. Thank you.

CHAIRWOMAN YOUNG: Thank you.

Our next speaker is Morris Auster, senior vice president and chief legislative counsel for the Medical Society of the State of New York.

Great to see you.

MR. AUSTER: Good evening. Thank you very much. I will also try to be brief. I actually have a 12-year-old who is home sick with the flu who has been texting me, when can I bring her home a milkshake.

(Laughter.)

MR. AUSTER: So I also want to go.

(Discussion off the record.)

MR. AUSTER: So good evening. My name is Moe Auster. I'm speaking on behalf of the

over 20,000 physicians, residents and medical students and members of the Medical Society. We represent physicians across the primary care and specialty care spectrum representing solo, small group, large group, and health system employees.

To begin with, I have to mention that more and more physicians are facing enormous challenges in remaining in practice to deliver patient care due to the untenable squeeze between rapidly rising practice costs and stagnant insurance payments. As a result, many physicians have basically felt they've had no choice but to become employed in various hospital systems. While that can actually help to reduce in some cases administrative burdens, it can also result in the elimination of jobs in some cases, as well as the disruption of some long-standing patient relationships. In fact, the number of employed physicians has actually doubled between 2012 and 2015.

While New York State has always been known to be a difficult place to be a doctor,

actually last year it was designated as being the absolute worst in the country, according to the website Wallet Hub, in large part due to our enormous medical liability premiums and relatively low reimbursements compared to other states in the country.

And these costs are going to go up, potentially significantly, as a result of the malpractice bill that was just signed into law. In fact, New York has by far and away the highest medical liability costs in the country, nearly three times as California. Why? Because in those states they've enacted reforms to help bring those down, while New York has not.

Given these dynamics, there certainly is a level of frustration among physicians that more is not being done to address various physician shortages across the state, and with the only solutions being offered -- what seems like I've heard multiple times today is to expand the use of non-physicians. Certainly there are other ways which we believe you can look at to address the

physician shortage, such as improving the practice climate in New York State.

Now, we will note that there are some positive initiatives in the budget. We are pleased that the Governor has funded the excess medical malpractice insurance program at a historical level without additional preconditions. We also appreciate that the Governor has -- is trying to initiate a conversation on some needed liability reforms by reducing the interest rate, by proposing to reduce the interest rate on judgments. And we support the proposal to disincentivize the use of use of e-cigarettes by taxing them similar to traditional cigarettes.

We all know, however, that there are many items in the budget with which we have concerns. It has been talked about before, the cuts to the Patient-Centered Medical Home project -- which has certainly helped a lot of physicians who historically have not been paid very well within Medicaid. It's actually helped to compensate them for a lot of the care management that they were already

doing.

They will face a significant cut on May 1st, according to the proposal, and will potentially be in a position to have to really ramp up very quickly into value-based payments, which they may not be ready to do. This may cause some folks to actually drop out of the program.

I thank you, Assemblyman Cahill, for also recognizing the -- commenting on the concerns with Minute Clinics that could potentially go into big box stores and drugstores. While MSSNY has had concerns about these proposals in past years, these concerns are magnified even more this year because it's occurring concurrently with the proposed acquisition of health insurance giant Aetna by drugstore giant CVS, which also happens to own a PBM, giant Caremark.

It's an enormous amount of concentration in the healthcare sector, which we're very concerned that they will take advantage of that power, in which it could be used to steer patients away from community

primary care practices and towards these retail clinics. At the very least, we should at least wait to see what happens with the federal government before this provision -- before we allow this measure to go forward.

Like the anesthesiologists, which you'll hear later on, we share their strong concerns with the proposal that would grant increased independence for nurse anesthetists in anesthesia delivery. We believe that the current system that's been in place for 30 years has served patients well and should not be changed.

And finally, we also note our concerns with the proposal to expand the existing collaborative drug therapy program that exists on a demonstration basis. We certainly would be okay with extending that program, but we do have concerns with potentially expanding it outside of the hospital, where a pharmacist may not have a common EMR. But we're willing to continue to talk about that.

We are also very concerned about

expanding it to include nurse practitioners. While many states across the country have established these collaborative drug therapy programs, it's our understanding that very few have actually extended it to nurse practitioners and pharmacists. And even those that have done it, in those states they still require a collaborative agreement between the nurse practitioner and the physician.

And finally, the last thing we note is our opposition to the proposed consolidation of the 30 important public health programs into the four pools, and urge that those -- that funding be restored.

And with that, there's a lot of things we had in the budget, I know I tried to do the elevator talk on each one, but I'll be happy to answer any questions you may have.

CHAIRWOMAN YOUNG: Any questions?

Well, you know how to track us down. So thank you very much.

CHAIRWOMAN WEINSTEIN: Thank you.

CHAIRWOMAN YOUNG: Our next speaker is

Jill Furillo, registered nurse, executive director of the New York State Nurses Association.

Welcome.

MS. FURILLO: Good evening. I represent the New York State Nurses Association, the largest organization of registered nurses in New York State, representing thousands of nurses in every healthcare setting. Whether it's in suburban areas, urban areas, rural areas, you name it, that's where we are, on the front lines of healthcare delivery.

We want to thank everyone for last year passing the enhanced safety net bill. It's very much appreciated. I do believe that when we passed it the year before, we were able to get some additional money into the enhanced safety net system or the hospitals that were identified such as the rural hospitals, the rural safety net, and the urban safety net.

So we are urging, again, that to be addressed in this Executive Budget. We stood

shoulder to shoulder with other people this whole last year in protecting, trying to protect our healthcare here in New York State, which we believe was under attack. We stood with the hospitals, we stood with the doctors, we stood with all of the other healthcare givers and with many of the elected officials. And we believe that we had some success in trying to stop the dismantling of the ACA, but of course as we all know, it's under attack now with the attacks through the canceled cost-sharing reduction payments, which is really going to significantly undermine the ACA.

We do support, in the contingency measures in the state Executive Budget, the authorized process for the Governor to make midyear budget adjustments in the event of catastrophic events from Washington that exceed $850 million.

We support the proposal to fund the contingency fund with a surcharge on any conversion of a not-for-profit insurer to for-profit status. We believe that the

$750 million per year that's generated should be targeted to support enhanced safety net hospitals to the tune of $500 million, and the remainder, $250 million, into the healthcare contingency fund.

Increase the health insurance windfall profit fee and support safety net hospitals. We support efforts to tax insurers' profits but propose an increase in the surcharge to 28 percent, with the $280 million that would be generated to be targeted to support enhanced safety net hospitals, using the definition in the 2017 vetoed legislation.

On the Vital Access Provider Assurance Program and the Value Based Payment Quality Incentive Program, we support the proposed increase of $68.6 million, and we believe that public hospitals that are currently excluded from this program -- we support making public safety net hospitals eligible.

In capital financing for essential healthcare providers, we support this ongoing program but believe that funding should be increased and clearly targeted to support

urban and rural hospitals that meet the definition of enhanced safety net hospitals.

We this year oppose the inclusion of budget legislation that threatens the nursing scope of practice. We believe that any legislation that affects nursing scope of practice should be hashed out in standalone legislation that is fully debated and is part of the regular legislative process, not in the budget.

And I just want to point out a couple of those. There is the authorization of community paramedic collaboratives, which we would like to have more conversation in trying to work that out in a way that would not affect patients in any negative way. As currently proposed, there's a lot missing, and we believe that patients would be at risk and that frankly it wouldn't achieve any cost savings. If you look at the studies, we know that registered nurses and licensed nurses are the ones that actually bring cost savings to the system through their care.

On the CRNA scope of practice and

licensing issue, we also believe that should not be addressed in the budget, that should be a standalone bill as well.

There's a lot of issues that need to be worked out. We believe that in the past, when we've done this kind of bill, some folks have fallen through the cracks -- and grandfathering, et cetera -- and we need to address that.

We stand with MSSNY on the opposition to corporate for-profit ownership and operation of the retail health clinics as proposed.

I'd like to spend just a second on the state reductions of psychiatric and mental health hospital capacity. You can read that in our written testimony. It's really a very serious situation throughout the state. It's becoming untenable, and I believe we're in a crisis situation when it comes to mental health.

And all the other issues you see in our written testimony. So thank you very much for allowing me to testify.

SENATOR KRUEGER: Thank you.

CHAIRWOMAN YOUNG: Thank you.

Senator Hannon.

SENATOR HANNON: Thanks for being quick.

MS. FURILLO: That's okay.

SENATOR HANNON: But I just am curious. Has anybody engaged you as an organization about this whole thing about the community paramedics proposal?

MS. FURILLO: There's been some conversations, but not really where we need it to happen. I think this proposal came out of one of the DSRIPs, and it was -- has not been fully vetted. We have concerns about it, but we also believe that we should be working on this as a standalone piece of legislation so that we can work through a lot of these scope issues, and that's our position on it.

SENATOR HANNON: Thank you. Appreciate it.

CHAIRWOMAN YOUNG: Anyone else?

Thank you so much for being here.

MS. FURILLO: Thank you.

CHAIRWOMAN YOUNG: Our next speaker is Dr. Carol Smith, president of the New York State Association of County Health Officials.

Welcome. Thank you for being here.

DR. SMITH: Good evening, Senators and members of the Assembly. Thank you so much for giving us the opportunity to speak to you tonight. You do have our written testimony, so I promise you I will be brief.

I am Dr. Carol Smith. I serve as the commissioner of health and mental health for Ulster County, and I'm also the president of the New York State Association of County Health Officials, NYSACHO.

NYSACHO represents all 58 local health departments across the State of New York and the City of New York. As local health leaders, it is our job to protect the health of the hundreds of communities and the millions of citizens that we and you serve.

As we all know, on the federal level in the past year there's been a serious challenge to public health. The CDC's

funding has been cut -- $1.35 billion will be removed from the CDC's public health and prevention fund over the next 10 years, and the CDC is now being pulled out of 39 of the 49 countries that it had previously served in. As we know, the work of the CDC has been on the front lines and is keeping our shores safe from the Ebola scourge that just broke out within the last couple of years.

Also, we believe we serve as the infrastructure for public health in New York State. We are in effect the first responders to public health disease outbreaks. We are also the standard barriers for prevention and for any programs in our community that help to prevent chronic diseases.

So we stand tonight, and I'll be brief, but we are asking you to oppose the 20 percent cut to the public health funds that is in the current 2019 budget. It affects over 30 programs that are sponsored by our community partners to help prevent chronic diseases such as heart disease, childhood asthma, and the scourge of nicotine

addiction, obesity among our adults and our children, and multiple programs.

We also ask you for some direct takes on the -- in the current budget -- we've asked for this in the past, we were asking for an increase in the Article VI-based grant from 650,000 to 750,000 for our full-service local health departments and an increase from 500,000 to 550 for partial service, an increase from 36 percent to 38 percent in the Article VI percent reimbursement above the base grant and an increase in the per capita reimbursement amount from 65 cents to $1.53.

The sad reality is that even in a tough budget year -- we acknowledge things are difficult, but New York's support for public health programs comprise just 1 percent of the Department of Health's Aid to Localities budget. Year after year, when fiscal times are tough, the first things that seem to be cut are programs in public health. This is undermining our ability to work within the counties that we serve to protect the food quality, to protect the water, and

to help prevent outbreaks of diseases. So streamlining efficiencies in our local health departments have really maximized to the point where we're seeing an eroding in our public health workforce and the infrastructure which is so critical to protecting the health of all New Yorkers across the state.

So thank you again for the opportunity to speak to you. We elaborate on these asks within our testimony, and I'll be happy to answer any questions that you might have tonight. Thank you.

CHAIRWOMAN WEINSTEIN: Assemblyman Cahill.

ASSEMBLYMAN CAHILL: Thank you, Dr. Smith, and welcome to Albany. And thank you for your good work back in my hometown and my home county.

DR. SMITH: It is my pleasure.

ASSEMBLYMAN CAHILL: You do terrific work there, and there's a lot of work to be done.

You mentioned, I think, 20 or 30 of

the things that you're involved with. Five come to mind that are just pressing, they're just urgent, in my view, almost a public health emergency. The opioid crisis --

DR. SMITH: Absolutely.

ASSEMBLYMAN CAHILL: -- keeping our water clean and making sure that it gets tested on a regular basis so that after it gets taken care of, we're sure that it stays that way.

Of course, we have long suffered in our part of the state with the scourge of Lyme disease and all that that has to do with.

DR. SMITH: Correct.

ASSEMBLYMAN CAHILL: And continued growth of -- maybe not growth, but the continued use of tobacco by young people has to be addressed.

DR. SMITH: Absolutely.

ASSEMBLYMAN CAHILL: And the last one is one we often forget that has become a very important public health one -- certainly not the last one you're dealing with, but the

last one on my list is the delivery of community-based services to a mental health population. It has to be an incredibly difficult task to -- many of those folks who are in that population are multiply diagnosed, they oftentimes have more than just a mental illness issue, they have physical issues, they have emotional issues.

When you face a budget that looks like it's going to not only not increase but result in a diminishment of that, how do you go about the point of figuring out how you're going to continue to deal with these emergencies, just these five? Not to mention the other 20 that you --

DR. SMITH: Absolutely. I mean, it is a daily threat or daily challenge. And you know I do have the distinction of having both the Department of Health and Department of Mental Health within my purview, which gives me a unique, I think, insight into how we can sort of look at the holistic aspect of the issue and stop funneling, you know, our efforts into one particular area versus

another, and look for the synergies that we can obtain by working with our community partners in new and novel ways.

So, you know, I think we've done a rather good job of that to date, but you know we're really reaching the point, I think, where our resources are so stretched that we've accomplished almost as much as we can do without really drawing upon the support of our community partners, the American Cancer and Mental Health Association, et cetera.

So funding to these community-based organizations is very much key to what we do in government to help preserve and to better the health of our citizens.

ASSEMBLYMAN CAHILL: I don't want to keep you much longer or my colleagues here, but specifically would you agree that the opioid crisis is different from one community to the next, that there is no statewide opioid crisis?

DR. SMITH: No, there is a state opioid crisis. And one of our asks really is to -- if there is the 2 cents charge per

milligram morphine equivalent of the opioid prescriptions, is to try to re-funnel that money back into the public health system. Because even though it's being called a public health crisis, the fact of the matter is -- and OASAS is a wonderful partner of ours, and as commissioner of mental health I work with them, I appreciate the work they do, the monies that come into our communities through the local governmental units, through OASAS. However, money is not being dedicated to the public health departments that would be looking at this crisis in a totally different perspective.

You know, we're looking at it from the multiple layers that it exists in. The supply in the community, the law enforcement, the educational piece to our schoolkids about the issues surrounding the opioid use, dealing with the aftermath of the opioid fatalities, the charges to counties to deal with the medical examiner issues. All county share, there's no state support for any of that, even though we're paying multiple

millions of dollars in the toxicology screens which allow us to say that that decedent had fentanyl or some other opioid in their systems. That's being borne by counties. There's no state assistance for that.

But you know, I can look at -- the medical examiner program comes under me as well. So in looking at the opioid problem from its many prongs, I think I'd be in a better position really to deal with bringing the community together to really evaluate it and to draw upon all of our resources to deal with it -- the law enforcement, the educational piece, and dealing with the medical providers, you know, and urging them to not prescribe the opiates, to go to the ibuprofen, et cetera, the less toxic and addictive compounds.

So, you know, I do have a lot to say about it, but I think that the health departments are uniquely poised to really do a good job in helping with the public health crisis, although they're not getting money to do it.

ASSEMBLYMAN CAHILL: I won't belabor it, but my point was that the crisis is different from community to community, not that it wasn't widespread across the state. And I would just -- this is not a question.

DR. SMITH: I think communities deal with it -- it might be a little different -- I think in effect it's very similar, to be honest with you, in speaking with my colleagues. But again, you know, as the health department we are not getting resources to deal with it.

ASSEMBLYMAN CAHILL: Right. I was just going to draw a parallel to the local nature of the problem to that which exists with making sure we have quality water, which I know is another problem. Sometimes it's a public water system, sometimes it's a privately owned water system, sometimes it's individual wells.

DR. SMITH: Right, but the health departments that are involved in -- especially the full service, and that's why I went with the increase to a full-service

department, because we're involved in the testing of public water systems and maintaining that they are free of contaminants that are so problematic.

ASSEMBLYMAN CAHILL: Well, I can't take up any more time. That clock has four zeroes on it, that means I can't talk anymore. So thank you very much.

DR. SMITH: But please, don't hesitate to contact me.

ASSEMBLYMAN CAHILL: Thank you.

DR. SMITH: I'd be happy to discuss this further.

CHAIRWOMAN YOUNG: Thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

CHAIRWOMAN YOUNG: Our next speaker is Director Neal Kalish, United Ambulette Coalition.

Welcome. Good evening.

MR. KALISH: First, good evening. I know you've all had a long day. Thank you very much for your time; I truly do appreciate it. I will attempt to be very brief here, as you do have my written

testimony in front of you.

The United Ambulette Coalition is a nonprofit industry advocacy group. We represent and provide a voice for the New York City ambulette providers. We work with the Department of Health, with you the Legislature, and the various agencies providing regulatory oversight. Our primary objective is to help ensure industry sustainability, and in so doing -- and most importantly -- that ensures that the Medicaid recipient has access to critical care and medical treatments.

We're seeking your help and your support on one issue that's really critical to us in the Executive Budget, and that is minimum-wage rate relief, which is dramatically, dramatically underfunded for our direct care workers as we wrestle with minimum wage which is spiralling upward, going to $15 at the end of this year in New York City.

In a forum like this, before I get specifically into the issue, I do like to

give some brief background on the industry and who we are and what we do, because I believe in many respects we keep many of the groups that were here speaking today -- New York City hospitals, dialysis facilities, nursing homes, adult daycare programs, drug rehab facilities, mental rehab programs, and virtually any other medical facility that is dependent on Medicaid recipients and serving the Medicaid population -- we keep them operational.

Oftentimes I believe we're overlooked because we are somewhat the tail wagging the dog in the Medicaid program. On a $64 billion-plus program, we account for less than 1 percent of that program. I believe it is very fair to suggest that without the service that we provide, the population we serve, truly the most vulnerable and most in need of the Medicaid population, would be under extreme duress if they could not access medically necessary care and treatments.

Briefly, and very specifically, we employ thousands of predominantly minority

employees -- drivers, matrons, and helpers aboard our vehicles that help carry wheelchairs and wheelchair-bound Medicaid recipients up and down flights of steps in non-elevator buildings in New York City, as well as mechanics, office clerical, logistics, admin staff -- now at $13, going to $15 at the end of this year. That's $22.50 overtime, and overtime is -- while we would like to curb it, it becomes very necessary in order to meet the needs of the hospitals which run 24/7 and the dialysis facilities which run close to that.

We carry wheelchair-bound clients up and down steps -- I already said that -- in non-elevator buildings. We help ensure the smooth transfer of dialysis patients in and out of treatment. We move in and out of some of the most dangerous and challenging housing projects in the nation, and in New York City we sit snarled in what is an average of 8-mile-per-hour traffic. If any of you have been there recently, it makes the work that we need to do very challenging.

The cost structure to operate in New York City is the highest in the country. We have the highest liability insurance rates in the country. We're moving slower with traffic than anywhere else in the city. It's very difficult and burdensome for us.

Specifically on the issue of minimum wage not being adequately funded in the Executive Budget, I put a chart in here basically showing that we have $7 million for next year. And Senator Savino, you had asked Mr. Helgerson this morning if direct care transportation was funded, and his response was it is funded in the budget. The missing component is that approximately 50 to 60 percent of the transports that we're now completing are going through MLTC programs, and that remains unfunded. There is no funding in the budget, and there is approximately $14 million that is needed to bring the rates for the MLTC side of the program up to the fee-for-service side.

And I think that it's important to note that on the fee-for-service side we've

had many meetings with the Department of Health fee-for-service, they've heard us out on our issue, they've analyzed data, they've analyzed our cost structure that we've presented to them, and they've taken appropriate action to move our reimbursement rates. That has not happened on the MLTC side, and that's where we need help.

On page 4 of this document I provide an illustration here. We have home care workers funded on both sides of the equation to the tune of almost $682 million. We have transportation funded right now at $7 million, and that falls dramatically short of what we need.

We're pleading with you, the Legislature, for your help and your support. The funding needs to be earmarked specifically for ambulette transportation so that it is in fact passed along to the ambulette provider so that we can fairly compensate our employees at the minimum wage.

Thank you so much. I will answer any of your questions.

SENATOR HANNON: Thank you.

CHAIRWOMAN YOUNG: Thank you very much.

MR. KALISH: Thanks.

CHAIRWOMAN YOUNG: Next we have President John Tomassi, Upstate Transportation Association.

Thank you.

MR. TOMASSI: Good evening. My name is John Tomassi, and I represent the Upstate Transportation Association. The Upstate Transportation Association is a not-for-profit association representing private passenger transportation companies. Our members include taxi, livery and in this case, for this purpose, medical transportation providers.

The issue we'd like to address today is the Governor's proposed carve-out of the medical transportation benefit from the MLTCs, which would shift the funding from Medicaid long-term-care plans and their brokers over to the Medicaid fee-for-service. We are in support of the program to implement

the carve-out. We believe doing so is the only fair and reasonable way to ensure transporters are paid properly and compensated for the minimum wage issue.

I think as we all know, when the managed care was set up, the whole idea was to give comprehensive care -- that the MLTCs could provide a complete service to their constituents. And that's how it started. But from the transportation side, that isn't how it is anymore.

On my attachment there's a list of all the MLTCs that have chosen not to handle transportation anymore but have passed it off to a third-party transportation provider who is now deciding the rates as well as who the providers are. So no longer are the MLTCs managing the transportation and choosing and selecting the transportation providers; that's being handled by third-party brokers.

The problems with that is that the -- obviously, the MLTCs are in a per-capitated rate, so where does this money come from to pay these outside brokers? It comes from the

rate that's being paid to the transportation providers. As such, today an identical trip in New York City under 5 miles on a fee-for-service and one provided by MLTC -- the MLTC side is probably 30 percent less for the exact same trip, because there's been a third party introduced, which is the outside transportation providers.

So our effort here today is to go back to a one fee-for-service to handle all -- since the MLTCs are no longer really selecting the providers, we're about to go back to a fee-for-service approach for all medical transportation.

As the speaker before me mentioned, there has been no money set aside for minimum wage last year nor this year. And by next year, it's up to $15. And MLTC has become 50 to 60 percent of the industry now, and growing, so it's becoming more and more of an issue for us.

Essentially, that's the essence of my -- of our effort here, is that we're looking to get a similar wage for our work

that we were getting from Medicaid, the Office of Medicaid, who as we've explained is deforming our costs and we're not getting anything from the MLTC side. The introduction of a third party seems to have taken a lot of the dollars allocated for transportation away from us.

CHAIRWOMAN YOUNG: Okay. Any questions?

MR. TOMASSI: Questions?

SENATOR HANNON: Thank you, no.

CHAIRWOMAN YOUNG: Very good. Thank you.

Our next speaker is Executive Director Kathy Febraio, from the Pharmacists Society of the New York State. And I believe she's joined by President Roxanne Richardson.

MS. FEBRAIO: Thank you very much.

CHAIRWOMAN YOUNG: Thank you.

MS. RICHARDSON: You guys really have stamina to do this. I'll start on page 1, that'll be good.

First of all, I'd like to thank you all for your past and continued support of

pharmacy in the State of New York and also our community pharmacies especially. I believe you all know the Pharmacists Society; the majority of our members are community pharmacists, and many of them are independent owners that own their own pharmacy.

What we want to do -- we have submitted testimony, but what we want to do is take this opportunity to be helpful in possibly helping close the budget deficit for the state. We have a way that you could generate money for the State of New York by the oversight and transparency of the multibillion-dollar PBM industry.

The PBMs have been around since the '60s. Back then, they were the little plastic card people, and we used the little machine and that was about it. And they paid the pharmacies. And they've become the multibillion-dollar industry responsible, we feel, for raising the cost of prescription drugs to the consumers, to New York State, and also to the health plans.

Just as an example, to generate the

$200 million in the Governor's proposed budget to treat the opioid crisis in New York, you would just need a fraction of their $300 billion annual revenue for the whole industry. The fraction that comes out to would be .00067. That would give you the $200 million, which comes out to .067 percent. So if you want to round it up to .1 percent, that would be fine too.

They work under secrecy. All their contracts are proprietary. They get the manufacturers' rebates they secure, which local community pharmacies cannot, in most cases. They have their own mail orders, which many times will try to convince the community pharmacies' customers to get the 90-day supplies -- which in some cases are fine; in other cases, that adds to the drug disposal problem and the opioid crisis.

The PBMs direct the providers to medications that they have secured the rebate for on their formularies, pushing market share for the drug manufacturers at the same time as they're reimbursing pharmacies at a

very low cost. Many times it's under what the pharmacy actually paid for the medication, and they capture the spread for themselves.

So unlike the manufacturers, they don't have costs for drug research and development or any of the risks associated with that. They don't have the brick-and-mortar costs of a community pharmacy, which is needed in the community to serve the patients. We really believe that.

In 2017, the three big PBMs covered 80 percent of covered lives in New York State. Here we are with the hospitals, the nurses, the other professionals, the health plans speaking to you today, and the only unregulated member of the healthcare space is the PBMs. That's it.

Many other states -- the ones that come to mind are Ohio, Kentucky, Arkansas, Alabama, Florida. Those are the ones we've just heard from lately that are enacting legislation and proposed legislation. West Virginia in this past summer, in 2017,

their Medicaid department just eliminated the PBMs, and since July 31st of last year they've saved $30 million.

So there is money out there, obviously, but nothing like that has happened here in New York. But we certainly wanted to propose that as a possibility.

New York needs revenue. The PBMs have been here in New York for a very long time with no benefit for the state that we can see, in our opinion. For these reasons, the society strongly supports and wholeheartedly recommends that New York join other states in finally tackling the issue of PBM management, regulation, oversight, and licensure.

And again, that .067 percent equals $200 million.

MS. FEBRAIO: On another note, pharmacists are very pleased they were able to vaccinate 6300 children in the ongoing flu crisis. We're also pleased to see that the Governor released today his 30-day amendments, codifying his executive order allowing pharmacists to vaccinate

children two to 18 years of age.

We look to clarify a question Assemblyman Oaks posed earlier. There would be no cost to the state to educate pharmacists to do so. Education and continuing professional development is the responsibility of the pharmacist. And current education for vaccination is set at the national level by the American Pharmacists Association and the CDC, and it currently covers the vaccination for children.

So any pharmacist vaccinating today an adult would be able to vaccinate a child as well. And this is just one example of how a pharmacist practicing at the top of their license and education could assist the state in some of the workforce development problems that they've been discussing today. They are an underutilized individual in the healthcare team.

Thank you.

SENATOR HANNON: Thank you.

MS. RICHARDSON: Any questions?

CHAIRWOMAN YOUNG: No. Thank you so much.

MS. RICHARDSON: Thank you.

CHAIRWOMAN YOUNG: Our next speaker is President Michael Duteau, Chain Pharmacy Association of New York State.

Welcome.

MR. DUTEAU: Good evening, honorable Chairwomen Young and Weinstein, Senators Hannon and Valesky, and other distinguished members of the Committee. Thank you so much for your past support of community pharmacy in New York and all that we continue to try to do to care for our patients here in New York State.

The Chain Pharmacy Association and our member committees are extremely focused on protecting patient access to pharmacy care and helping strengthen the relationship and the role that a pharmacist can play in improving patient health outcomes while reducing costs.

With that being said, we echo the comments of PSSNY. We are extremely pleased

with the Governor's press release this morning that he seeks to make his executive emergency order permanent, allowing pharmacists to immunize children. Community pharmacies are extremely accessible, open nights and weekends, and this would allow entire families to get their flu shot in one visit.

I think they mentioned also that community pharmacies over the last two weeks literally mobilized overnight, and since then have immunized 6300 children. We greatly appreciate your support in making this important treatment option available to all families in New York State.

I'd like to briefly comment on four proposals within the Executive Budget. First and foremost, I would like to state that we fully support the efforts to prevent opioid addiction and the devastation that it can cause to individual families and entire communities.

We also agree that more must be done to discourage inappropriate opioid use and

create more accessible and effective treatment programs across our state. And I think it can be said that by introducing I-STOP and other effective legislation, New York has led the way nationally in fighting the opioid epidemic.

However, upon close review of the Executive Budget, we oppose the proposal to impose a surcharge on opioids to be paid by the establishment making the first sale in the state. Upon further review, we have come to determine that pharmacies would most likely be the most often affected entity -- not manufacturers, not wholesalers. There are few manufacturers and few wholesalers in New York. There are thousands of community pharmacies that could be on the hook for paying this tax when dispensing the drug directly to patients.

Two quick examples. We've done some math using some industry cost analysis, and for a drug that might cost $2, the New York State surcharge, proposed surcharge, could be $10. For a $50 bottle of morphine,

100 milligrams, that same tax could be $200.

Pharmacies' reimbursement is based on our costs, so if you're layering on a $200 surcharge and we are the ones paying it, unfortunately, many operators, many pharmacists may decide not to stock that medication, which ultimately would be negative for patients who have a legitimate need for those drugs.

With that being said, we would ask that you reject this proposal, or at the very least amend it to exclude pharmacies so that we can continue to care for patients without being penalized.

Now, I know it does seem odd for me to sit here before you and say that I'm here to talk to you tonight about an increase in Medicaid reimbursement. But we do have an 8-cent increase in the cost of dispensing fees in the budget. And while we do not feel that that reflects the national average for the cost of dispensing, we are grateful that it was included in the budget and we request that the Legislature consider numerous other

ways to continue to properly reimburse pharmacy for their services in the dispensing of important prescriptions.

We also support the proposal for comprehensive medication management. This is a voluntary proposal that would allow physicians, pharmacists, and patients all to work together to improve patient health care. By allowing a pharmacist and a physician to form a voluntary collaborative practice agreement, that would streamline the treatment plan as well as the communication.

And we're currently doing this with other initiatives such as immunizations, where we use a protocol and a standing order in conjunction with a physician's authorization. We feel that it is an excellent way for pharmacists to expand how they care for patients, and we also feel that there is added financial value in helping pharmacists reduce the cost of healthcare in many areas of the state.

Finally, the last two proposals we oppose are related to Medicaid copays. One

of the proposals would raise the Medicaid copay from 50 cents to $1. We have been here before testifying that most patients indicate they are unable to afford their current copays, to pay their copays, which indicates to us that it's already too high. If you're raising it to a dollar, we think that that number would only increase. And of course if a patient is unable to pay their copay, that amount is deducted from the pharmacy reimbursement. We are not able to collect that amount.

Finally, the budget also proposes reducing the amount of over-the-counter products available to Medicaid patients. Over-the-counter products are a cost-effective, first-line defense to a lot of patients who have been used to having them as a prescription item. If it's removed -- some examples would be digestive aids, multivitamins, even some important cough and cold products. If they don't have access to them as an over-the-counter prescription, two things could happen. Number one, they would

go without any type of treatment, or number two, a physician might decide to prescribe a more expensive treatment, which I think defeats the purpose of having that on the formulary.

So we would ask that you would reject both of these two proposals and keep Medicaid products in place and copays at the current level.

Thank you very much for your time.

CHAIRWOMAN YOUNG: Questions?

Thank you.

SENATOR KRUEGER: Thank you.

CHAIRWOMAN YOUNG: Our next speaker is Director of Health Policy Bill Hammond, from the Empire Center for Public Policy.

Welcome, Bill.

MR. HAMMOND: Thank you. Good evening, Senators, Assemblymembers. I appreciate you listening to us all day.

I am in the glass-half-full school of thought; I don't think there's an immediate crisis of healthcare funding. Among the other things that survived last year was the

Medicaid expansion, and that's been quite generous to New York. As a result of that, we're seeing our Medicaid matching aid actually increase. It went from 53 percent last year to 54 percent this year -- that's $2.3 billion. And I think we can expect a similar amount going forward, at least for the time being.

Even if there were -- and as of last week, as we've heard many times today, Child Health Plus, DSH, community health centers were all restored. With the exception of the cost-generating reductions, which I'll talk about later. Even if there were a crisis, I don't think it makes sense to, as the Governor's proposal would do, raise revenue from the healthcare industry in particular. Medicaid and these other health programs, if they're worth doing, they are shared responsibilities. And singling out health insurance can be counterproductive, because it makes health insurance more expensive for those who buy it and pushes people onto the Medicaid system.

So in that category would be the 14 percent surcharge on underwriting gains. I would point out that it probably exempts large employers who self-insure, because they don't have technically underwriting gains to pay tax on. And so the burden of that would fall primarily on small groups and individuals, and I think they're kind of the last people who we should be asking to pay more for their health insurance.

And the other point to make is that this is a rare example where they might be due for some rate relief, or at least less of an increase, if because of this tax cut we have existing regulations and oversight from DFS, that would likely ensure that all or part of the tax cut would go to the consumer.

I don't think the Fidelis -- taking the money from Fidelis is justified. This is a charitable organization. As we heard from the bishop, he wants to spend that money doing good work around the state. I don't see a good reason why the state should take it.

And I guess another angle on this that I think is kind of interesting is that Centene is going to be doing the work that Fidelis used to be doing while paying taxes, so the transaction is a net positive for the state and local government. And I don't think you want to blow it up by taking away too much of what the bishops would be receiving.

The opioid tax, if --

SENATOR HANNON: It's not us blowing it up. It's the Governor.

MR. HAMMOND: I'm using the royal "you," I guess.

(Discussion off the record.)

MR. HAMMOND: The opioid tax, I think a lot of that would be paid by Medicaid. I looked up some numbers -- in the first six months of 2017, New York State Medicaid paid for 22 million oxycodone pills. That's more than one pill for every resident of New York. I did some rough calculations; it works out to something like 500 million morphine milligram equivalents. So that's $10 million

paid by the Medicaid system for six months on one drug. So that's a bit expensive, if my math is correct.

I don't think it's a good idea to go after the reserve funds of the Medicaid managed care plans. You're penalizing responsible behavior. The Governor is proposing $425 million in capital grants. I feel like those -- there are some institutions that need capital support. I don't feel like that money's been distributed -- not all of it has gone to struggling facilities. Some of it has gone to quite well-off facilities.

And I've used up my time, so ...

CHAIRWOMAN YOUNG: Any questions?

MR. HAMMOND: Thank you.

SENATOR KRUEGER: Thank you, Bill.

ASSEMBLYMAN CAHILL: Bill, just a quick comment. While you are certainly an engaging speaker, clearly I read your testimony -- you're still a better writer.

(Laughter.)

MR. HAMMOND: Oh, thank you.

ASSEMBLYMAN CAHILL: And thank you so much for not using the one line in here that I underlined, and I'll show you later.

MR. HAMMOND: Oh, I know. I know what you're --

ASSEMBLYMAN CAHILL: Yeah, keep going.

CHAIRWOMAN YOUNG: The next speaker is President Cheryl Spulecki, New York State Association of Nurse Anesthetists.

Thank you for being here.

MS. SPULECKI: Thank you for having me. In addition, I'll be joined by Dr. Juan Quintana, past president of the American Association of Nurse Anesthetists. His testimony is before you as well, and has been submitted online.

So good evening to the distinguished members of the subcommittee. Again, I am Dr. Cheryl Spulecki, a certified registered nurse anesthetist and current president of the New York State Association of Nurse Anesthetists, also the assistant program director for the Nurse Anesthesia Program at SUNY at Buffalo.

I am testifying today for full scope of practice support for certified registered nurse anesthetists as part of the healthcare budget. NYSANA, as you may know from us being here year after year after year, represents nearly 1600 certified registered nurse anesthetists and student nurse anesthetists. We have been coming to Albany all this time looking not only for state recognition but scope of practice, as we are advanced practice nurses, commensurate with our national certification, our advanced education, our clinical training and our expertise.

And we are grateful to the Governor for adding us to his budget proposal, as well as to Assemblyman Gottfried for carrying our bill as well.

More than 30 years of scientific study, evidence-based research, demonstrates that CRNAs not only administer safe anesthesia -- I said safe anesthesia -- cost-effective quality care with patient outcomes that are equivalent to other

anesthesia providers. We practice in every setting currently. Every type of procedure, every complex procedure, every category of patient, including those metropolitan facilities such as Memorial Sloan Kettering, Level 1 trauma centers such as Erie County Medical Center, suburban locations such as South Buffalo Mercy in Buffalo -- and most importantly, those rural critical-access sites: United Memorial Medical Center in Batavia, Mount St. Mary's Hospital in Lewiston, Wyoming County Hospital System in Warsaw, as well as Brooks Hospital in Dunkirk, New York.

It's been well established that when anesthesia is provided by a nurse anesthetist, it is the practice of nursing, and when provided by a physician it is the practice of medicine. Similar to other specialties, there is overlap. But it is important to realize that it is administered exactly the same way. Our techniques are the same, the equipment and the anesthesia agents are the same, and most importantly our

patient outcomes are the same.

It is obvious to those in New York and across the United States that anesthesia services will be outpaced by the number of providers that are necessary in the next several years, and we are looking for enactment of scope of practice in law.

CRNAs often work in areas with low median income, higher unemployment, uninsured and higher Medicaid-enrolled as compared to anesthesiologists. That's a fact. The geographic balance is no more pronounced than in our rural counties across upstate New York as the sole anesthesia provider in most rural hospitals.

Allowing us to practice as advanced practice nurses is currently afforded to the nurse practitioners, the nurse midwives, and clinical nurse specialists. We'll not only continue to ensure patient access amongst the vulnerable populations, but help New York State meet the needs.

The bottom line is removing restrictive barriers to practice -- including

outdated, unnecessary supervision requirements -- translates into greater access to more efficient and cost-effective care for our hospitals at a time where it is needed most fully around New York State.

We have time and time again been challenged with our education to know that CRNAs are part of a challenging, rigorous program, anywhere from seven to eight to nine years of education, and being that we are the only provider currently with intensive care training as an ICU nurse before being accepted into our program, as compared to any other anesthesia provider. Our candidates are emergency flight registered nurses, cardiac pediatric, and surgical ICU nurses. New York State has been blessed with three top-notch schools that have been nationally ranked: Columbia University; the Albany Medical Nurse Anesthesia program; and the SUNY school, University at Buffalo, ranked within the top 10 of the country. Our students currently are graduating with a master's degree, a doctoral degree, years of

education above and beyond, with underlying -- again -- ICU experience.

I'd like to thank you for the opportunity to speak publicly about the support for full scope of practice for nurse anesthetists. We would love to make this the year we finally achieve what 48 other states currently have. And we will continue to provide what we have been known to do -- provide safe, high-quality, cost-effective anesthesia services to the residents of the state and around the country.

DR. QUINTANA: Good evening. I'm Dr. Juan Quintana. I'm a certified nurse anesthetist. And I just wanted to quickly address -- first, I want to commend you all this evening for -- wow, still hanging out here, huh? You guys rock. And so certainly the citizens of New York have a lot to be proud of. You've heard a lot of information today.

I just want to say certified registered nurse anesthetists didn't just pop up. We've been around for an extremely long

time -- at least 150 years, by many accounts. Gallup Polls show that nursing as a whole is one of the most trusted and ethical professions in the nation, 16 years running. I don't know why I like that, I just do. It's something about nursing, right? And so I like to present that.

Myself, I have a business in Texas where I provide anesthesia services. I am the sole proprietor, and I actually provide services in a rural county where there are no other providers. So this is not unique or something different, something new that's come about; this is something that's been in practice for a long time.

We're excited at the national level to hear that New York is actually considering codification of the CRNA practice as something that is part of that APRN, Advanced Practice Registered Nurse contingency. You know, we're excited because we've been waiting, we're thinking yeah, good, this is about time, right? Why has this been prolonged?

We know, as Cheryl mentioned earlier, that CRNAs practice in all kinds of settings, every setting that you can think of, and we practice with all kinds of physicians, gastroenterologists, ophthalmologists, all of them, and we practice in the military, which is something that often goes unnoticed, in forward surgical teams. In fact, CRNAs are the designated anesthesia provider for forward surgical teams in the line of conflict.

In rural America, there are places where CRNAs provide 100 percent of the anesthesia and there are no other providers available. In terms of our education, sometimes it's called into question -- you don't have as much education, we're told, as your anesthesiologist colleagues. That is absolutely, 100 percent correct. Our education follows a different format. We are nursing, then master's and doctorally prepared individuals providing anesthesia.

And so I bring that out to you because there was some concerns by the Assemblywoman

from Brooklyn, I believe, about a two-tiered system. We provide the exact same type of anesthesia services to all our patients. It is the same format, we study the same books, and we do the exact same thing.

We have studies -- in case you're worried, we have three really good studies that tell us, number one, that in fact we are the most cost-effective provider for anesthesia services; number two, that comparing the states that have opted out of a supervision rule to states that still have it, there is no difference in the service; and, number three, that erecting barriers like supervision barriers creates no difference in the outcome. Whether the CRNA provides the service or whether the anesthesiologist provides the service or whether they do it together, there's no difference.

So you can feel safe in the fact that we continue to provide a high-quality anesthesia service that is cost-effective and -- I mean, the reverberation I heard

through the room from the Hospital Association, from everyone else, is that we need revenue, right? This is -- we need revenue, we need access. This is an excellent way for New York to amplify the number of CRNAs that are utilized here and at the same time reduce the cost of the services, because the hospitals and facilities bear that cost.

So I'll leave it at that and just encourage you to seriously consider it. We are nursing, we're here for you. We're here for your children, for your mom, we're here and we take care of you every single day, and we would love this consideration.

I thank you.

CHAIRWOMAN YOUNG: Thank you very much.

SENATOR KRUEGER: Thank you.

CHAIRWOMAN YOUNG: Thank you.

I would remind the speakers to stay within the five minutes that they are allotted. Our next speaker is -- actually there are two. Dr. Rose Berkun, M.D.,

immediate past president, and Dr. Vilma Joseph, M.D., secretary, of the New York State Society of Anesthesiologists.

Welcome.

DR. BERKUN: Chairwoman Young, Chairwoman Weinstein, Assemblyman Cahill, Senator Hannon and all respected members of this committee, I am Rose Berkun, a board-certified physician anesthesiologist and also immediate past president of the New York State Society of Anesthesiologists, a medical society consisting of 3700 physician anesthesiologists with a primary mission to provide the safest and highest quality of anesthesia care to the citizens of New York State.

We're here today to bring to your attention our profession's grave concerns in opposition to the proposal in Part H of the health budget which would allow nurses to administer anesthesia without any physician supervision and would provide unrestricted prescriptive authority to more than 1200 mid-level providers untrained in pain

medicine to prescribe narcotics at the time of the largest opioid overdose crisis we have ever seen.

Our biggest concern is patient safety. Current laws and regulations mandating physician supervision require physicians to be immediately available to manage medical emergencies. Independent studies -- one of those we included for you to read -- have shown that the chances of an adverse outcome are significantly higher when anesthesia is provided by an unsupervised nurse anesthetist. Physician anesthesiologists complete a bachelor's degree, four years of medical school, and 12,000 to 16,000 hours of clinical medical training.

Nurses are trained to work under the supervision of physician anesthesiologists, and not independently. Nurses have neither the level of education nor training of physicians. The bill grants authority for nurses to perform pre-anesthesia evaluations, anesthetic induction, and emergence. These are functions that they have not been trained

for or allowed to perform without direct supervision of physicians.

As for the cost savings, this proposal incorrectly claims that there is $10 million in savings to New York. Under Medicare and Medicaid, the reimbursement for anesthesia services is exactly the same whether it's administered by a physician anesthesiologist, anesthesia care team, or a nurse anesthetist.

As for access, we do not have a shortage of anesthesia providers in New York. Our association survey of New York hospitals found no hospitals in the state are performing surgeries without access to a physician anesthesiologist. The 2016 American Medical Association workforce study determined that out of 1276 nurse anesthetists practicing in New York, over two-thirds -- 870 of them -- practiced from Albany down south. This provision will not expand coverage to the western part of the state.

In conclusion, we'd like to say that I agree with our esteemed nurse anesthetist

colleagues that anesthesiology is the practice of medicine and it should be determined by education and not by politics. We also agree with the New York State Nurses Association that CRNA's scope of practice language expansion should be taken out of the budget.

Thank you.

DR. JOSEPH: As Dr. Berkun stated, the Legislature should reject the Governor's proposal and not risk the safety and well-being of all New York citizens.

I'd like to add some other reasons. Let's talk about discrimination and healthcare disparities. I'm very disturbed that this proposal will create a two-tier care system in my community. I work in the Bronx. Trust me, it creates a system where the quality of anesthesia care will be determined by a patient's insurance or some other socioeconomic reasons. Those with resources will be cared for by physicians, and those without will be cared for by nurses.

Now, with regards to the opioid crisis, we are all aware that it's devastating our communities and creating many unnecessary deaths. Now this expansion of scope of practice will allow approximately 1,300 to 1,600 undertrained and unsupervised prescribers to write opioid pain medication, and will exacerbate this crisis. Anesthesiologists are trained in opioid-sparing pain medicine techniques and are the experts in this area.

Now, what about patients' rights? Our anesthesia patients are at their most vulnerable while being rendered unconscious for surgery. They should continue to have the right to have a physician anesthesiologist who is properly trained to supervise their anesthesia care.

Finally, every day I work with nurses on our anesthesia care teams. I respect their work and their participation. However, the medical practice of anesthesia is not a collaborative practice. When the patient's life is on the line, seconds count. There is

no time for discussion. As a physician anesthesiologist, we are trained to act decisively due to our medical education. Nurses do not receive the same level of training and are not equipped for this level of practice expansion.

This proposal dangerously weakens anesthesia care in New York and may lead to a high mortality rate. Dr. Berkun and I, on behalf of the 3,640 members of the New York State Society of Anesthesiologists, call upon the Legislature to keep anesthesia safe in New York and reject the Governor's proposal.

CHAIRWOMAN YOUNG: Any questions?

Thank you.

DR. BERKUN: Thank you.

DR. JOSEPH: Thank you.

SENATOR HANNON: Thank you.

SENATOR KRUEGER: Thank you.

CHAIRWOMAN YOUNG: Our next speakers are Lauren Pollow, director of government affairs, and Executive Director Amy Kennedy, from the New York State Center for Assisted Living.

Again, please adhere to the five minutes. Thank you for being here.

MS. KENNEDY: Thank you.

Good evening, and thank you for allowing me the opportunity to testify on the Health and Medicaid proposals included in the 2018-19 Executive Budget. My name is Amy Kennedy, and I serve as the new executive director of the New York State Center for Assisted Living, known as NYSCAL, the assisted living arm of New York State Health Facilities Association, NYSHFA.

CHAIRWOMAN YOUNG: You have quite lengthy testimony. Could you please summarize it for us?

MS. KENNEDY: Sure.

So as a registered nurse and a former executive director of an adult home and assisted living programs and an enriched housing program for 25 years, I've witnessed how the landscape as a provider has had to acclimate to the multitude of changes in the delivery of care of the population. Please read my testimony to expand on what I have to

say.

We are pleased to see in Governor Cuomo's Executive Budget different options to expand access to the ALP programs for existing providers and development of new programs where there is a demonstrated need. NYSCAL is supportive of the expedited 90-day review process for the ALP slots. The number of additional assisted living beds will be based on previously awarded beds withdrawn or denied by DOH, and additionally for ALP providers licensed on or before April 1, 2020, who may apply for an additional increase of nine beds every two years.

We are also in support of awarding 500 additional ALP beds in counties where either one ALP or no ALP providers are present. These providers provide service only for public-pay residents, and maintain a collaborative agreement with an ACF, a nursing home, or a general hospital. So it's 500 beds in counties where utilization of existing program beds is higher than 85 percent, and the second 500-bed proposal

is for the solicitation and award of ALP beds in counties where there are no ALP beds or only one ALP provider.

MS. POLLOW: There is an addition to that proposal requiring that those providers, in order to qualify for those expedited slots or enhanced slots, would need to have managed-care contracts. We're slightly concerned with the timing of that, given the rocky implementation of managed long-term care in the nursing home setting. We feel as though that requirement should be stricken given the time-sensitive nature of ensuring access to ALP in the next several years to meet the requirements of low-income seniors in the areas that they're serving.

And to add two additional points before we wrap today, we would like to say that we're in support of the Governor's proposal for including assisted living providers in a list of community-based providers for the Statewide Health Care Facility Transformation Program funding. We have seen nursing homes who have qualified

with transformational projects benefit greatly from this funding.

Unlike the last two rounds in solicitations, our providers and other community-based providers were not qualifying entities, so we'd like to see that proposal mirrored in the Legislature's one-house proposals and, hopefully, the enacted budget.

And additionally, one item that we were disappointed we didn't see in the Governor's Executive Budget was -- the item I know you're familiar with is the SSI increase. We thank the Legislature for having passed this unanimously in both houses last session. As you're well aware, those receiving SSI are served in adult homes and enriched housing programs. They're receiving non-residential care services because they are longer able to live independently. This is a bargain for the State of New York. These are individuals who would be discharged to higher cost settings if they didn't have this option available to them.

Not to belabor the point, but the

Governor had a very robust list of social reforms, as usual, in his testimony. And, you know, he said we should hold ourselves to a higher standard. It's our obligation as a caring people, a compassionate society, to reach out and provide whatever social services or address whatever needs individuals present, and we couldn't agree more. So we do feel as though supporting ACFs and allowing for this increase would support seniors to live in an HCBS-compliant setting. The current rate of $41 per day is wholly inadequate.

I won't discuss that further because I know that we've, you know, just beat that to death in past testimony. But we really appreciate your support, like last session, and hope to see this in each one-house proposal.

Thank you.

CHAIRWOMAN YOUNG: Thank you.

MS. POLLOW: Thank you.

CHAIRWOMAN YOUNG: Questions?

CHAIRWOMAN WEINSTEIN: No.

CHAIRWOMAN YOUNG: Thank you very much.

Our next speaker is Executive Director Lisa Newcomb, Empire State Association of Assisted Living.

Thank you for being here.

MS. NEWCOMB: Hi, thank you. I will be brief, less than five minutes.

I am Lisa Newcomb, as you said, the executive director of the Empire State Association of Assisted Living.

I will focus my testimony on two areas: The urgent need for an immediate increase in the supplemental SSI rate for our low-income seniors -- it's $41 a day, as the ladies had just mentioned -- as well as our second priority is the need for a process which rationally awards Assisted Living Program beds, also as mentioned.

With regard to SSI, I want to thank the chairs and both houses for passing a $20 increase last year. For a very brief moment, we were hopeful that we would find much-needed fiscal relief. However, Governor

Cuomo vetoed this critical legislation. In his message he stated that any proposed increase to the state supplement must be handled in the Executive Budget. Regrettably, and inexplicably, he has failed to include any funding in this budget.

Notwithstanding the state of crisis faced by the providers serving low-income residents where facilities are closing at an alarming rate -- 25 have closed since 2014, 12 of them within the last 12 months.

In years past, testifying on behalf of ESAAL was a local upstate provider, Jim Kane, who I know some of you know. He is not here this year because his facilities have either closed or they are being sold. Needless to say, he and his staff have become victims of inadequate funding. But more importantly, by failing to increase the SSI rate, the state is failing more than 12,000 seniors throughout New York State that rely on SSI.

As many of you have now heard, the SSI rate of $41 day that we spend on housing and caring for our most vulnerable seniors is

less than the daily cost of boarding a dog in a kennel. We've been saying that for about 20 years now, and it is still the truth.

This reimbursement is unsustainable in light of the increased mandates -- most especially, the ultimate back breaker was the $15 minimum wage, which has really devastated us. We estimate about $170 million annually, which means the minimum wage alone is approximately $34 per day. That leaves us with $7 a day to provide food, services, housekeeping, personal care, case management, as well as all of the insurances to some very frail and vulnerable people. It's simply not possible. And amazingly, unlike all other healthcare providers, the adult care facility industry received no assistance to bear the cost of this mandate.

So when our facilities close, what are their options? You're going to be paying more because they're going to nursing homes, so you're going from the $41 a day to between approximately $150 to $250 a day in a nursing home under Medicaid.

Where we have found programs that were working, such as the Medicaid Assisted Living Program -- and we thank you for your support of that program -- in the past the Governor has moved to prevent the expansion of this program. But we have fought to bring the ALP program under the certificate of need process, another bill that you passed -- and thank you again -- last year, only to be vetoed by the Governor.

While we applaud the addition of ALP beds in the budget, there needs to be a rational and transparent process for the award of such beds. Please revise the proposal to reflect a formal application process comparable to the bill unanimously passed last year.

We implore you to help this growing industry that is serving seniors that are choosing to live there every day, and we could use your financial support.

Thank you.

CHAIRWOMAN YOUNG: Thank you very much.

SENATOR KRUEGER: Thank you.

CHAIRWOMAN YOUNG: Our next speaker is Lauri Cole, executive director of the New York State Council for Community Behavioral Healthcare.

MS. COLE: Good evening.

CHAIRWOMAN YOUNG: Good evening.

MS. COLE: We thought we'd give you the bargain of the two of us together. We're comrades, and so we're both on the list and we combined our time, if that's okay.

CHAIRWOMAN YOUNG: Okay.

MS. COLE: Okay, you're welcome.

So my name is Lauri Cole, I'm the executive director of the New York State Council. And very briefly, we represent mental health and substance abuse addiction treatment providers across the state. That includes community-based freestanding organizations, hospitals that provide behavioral health services, as well as counties that continue to deliver them as well as administrate over them.

And so I'm here today both as an

advocate over the last 30 years for mental health and substance abuse services, as well as recently, unfortunately, the bereaved significant other of a person who died as a result of the opioid crisis.

And so I'm shaking. So I wanted to talk to you about the opioid surcharge. I have nothing in front of me but, you know, I have my head and my words. The opioid surcharge proposal, we think, is probably the greatest hope of getting the infusion of revenue and funding that the system desperately needs across New York State. There is a kind of collective trauma that is occurring in our workforce as people working in programs, residential outpatient clinics, et cetera, continue to treat individuals one day and learn that they're no longer with us the next.

Our workforce desperately needs resources. In addition to educational and all kinds of financial incentives, we need to be able to address the trauma that is occurring in our programs and services and

really take a look at the recruitment and retention problems that we already had before this crisis multiplied to the extent where people will do anything rather than working in our programs and services.

So the opioid surcharge right now, as we read it, does not explicitly state that the money from the revenue would go directly to OASAS. And this is vital. As we've talked about here today, "trust but verify" is my motto. We've asked the Executive to direct 85 percent of the resources associated with the revenue from the surcharge directly to OASAS for prevention, treatment and recovery services to include new initiatives. In fact, for it to be about new initiatives, not to offset costs of previous budgets and previous appropriations.

So we need your help. And I'm happy to take a question or two after my colleague Andrea is done. But I just wanted to thank you in advance for your support. I see heads nodding and -- it's not a perfect situation, it's not a perfect revenue item, but it is

probably our greatest hope of some new resources into the system.

Thank you.

MS. SMYTH: And thank you for your forbearance. I'm Andrea Smyth, the executive director of the Coalition for Children's Behavioral Health.

The Legislature was very supportive last year of #bFair2DirectCare. We appreciate that. You were also supportive of expanding the number of providers or types of providers that would be eligible for statewide health facilities capital funding -- but the children's residential treatment facilities were not included in that eligibility.

So after four years of trying that tack, I'm going to try something different. I'm going to propose that you consider the fact that there was $10 million added for children's mental health capacity, capital money last year from the Legislature, and this year the Executive proposed $50 million for mental health facilities improvement.

Maybe we work in that atmosphere, in the OMH budget, instead of trying to change something in the statewide facilities budget.

Again, we have a modest request to do some carve-outs on the crisis, money that's proposed to make sure children's services are addressed appropriately and to repeat the investment last year specifically addressing the residential treatment facilities.

You're no strangers to scope of practice concerns. I heard a lot of them today. We have our own problem proposed in the Executive Budget. Again, we were offered, with the exemption to the clinical practice, a process between last year's extension and this one. That process didn't take place.

We are fifth in the nation in mental health labor shortage. Anything that is done to change the status right now of who we are using to provide services will only exacerbate that. We're fifth now, and there's a proposal to create a new bottleneck that we just cannot afford to have happen

when we have children waiting and waiting and waiting to get referred to care. So I ask you to look carefully at Part Y of the Executive Budget proposal in the Mental Health Article VII bill related to the scope of practice.

And lastly, just relating to a surprise in the budget. As recently as December 5th, the Children's Medicaid Redesign Team met. We were informed that the Medicaid design transformation for children would go ahead as expected July 1st. My providers had changed practices, hired people, they have closed programs. They have invested millions.

And this budget proposes a two-year delay to putting new children's services out for the communities. The school districts wrote a report, they cannot access behavioral health services, they're trying to pay for it in the education budget. Children's mental health is in a crisis. My testimony shows that you've written checks for these new services to be -- to come up in the past.

The money's there. There's no reason to try to save it again for the third year in a row.

I urge you to put money on the streets for children's behavioral health. We're talking about $15 million.

MS. COLE: I second the motion.

CHAIRWOMAN YOUNG: I'm just curious. So the Mental Health hearing is tomorrow, but you chose to be here today.

MS. COLE: Yes. Yes.

MS. SMYTH: It is very difficult, since we have broken out the responsibility for the Medicaid budget to be solely in the realm of DOH, because the Office of Mental Health doesn't have a role in the budget restorations that happened in Medicaid. That happens here. And so we struggle to try to figure out really who we need to be talking to. We'll submit testimony tomorrow, but this is a Medicaid request. This is a Medicaid global cap problem, and it's very challenging.

MS. COLE: We've been here on issues like uncompensated care, Medicaid APG,

government rates -- these are all issues that are the responsibilities and purview of this table, so I've been coming here for years.

CHAIRWOMAN YOUNG: Okay. Well, thank you very much.

MS. COLE: Thank you.

MS. SMYTH: Thank you.

CHAIRWOMAN YOUNG: Our next speaker is CEO Louise Cohen, Primary Care Development Corporation.

MR. KWAN: I am not Louise Cohen --

CHAIRWOMAN YOUNG: Okay.

MR. KWAN: Unfortunately, Louise had to go back on the last train to New York.

My name is Patrick Kwan, K-W-A-N. I'm the senior director for advocacy and communications for the Primary Care Development Corporation.

For over 25 years we've been working in the State of New York with over 600 healthcare sites throughout the State of New York, every corner, helping to expand and strengthen primary care throughout by providing capital investment, practice

transformation, and policy advocacy in support of the primary care sector.

I would like to thank the Legislature for the previous appropriation of the $19.5 million for community healthcare involving capital funds as we talk about the opioid crisis throughout today.

I also want to mention that one of the projects that we're very excited about is up in Saranac Lake. It's going to be an integrated outpatient facility with primary care, 24/7 access, and referrals to keep outside of expensive emergency room visits and integrate a care that will help people with the opioid crisis. And we are expecting the facility to open in December of 2018.

And the revolving capital fund allows us to make sure that we get the dollars and financing quicker to facilities so that they can build and meet the needs quicker in the State of New York with the facilities throughout the State of New York, that we do have an immediate need to expand these facilities and services throughout the State

of New York. And we thank the Legislature in support of the Community Health Care Revolving Capital Fund.

Nationally, in the State of New York, primary care is undervalued and underfunded despite evidence that it improves health outcomes and reduces cost. Primary care transformation efforts underway throughout the State of New York, through DSRIP and other initiatives -- you know, while they very much rely heavily on primary care to deliver the better care outcomes, better at lower cost, they do not provide the full and necessary support to ensure success.

Simply, our recommendations include that DSRIP should provide a more significant portion of funding directly to primary care providers. Currently, it's under 5 percent. New York State should maintain its robust PCMH incentive payments, and the New York State healthcare capital programs should increase the proportion of dollars directed to primary care and community-based health care providers.

We also want to thank the Legislature for including the $400,000 for PCDC in the final 2018 budget, and we're very appreciative of that continued support. The funding allowed PCDC to undertake important initiatives to ensure sustainable growth of primary care in underserved communities.

We also would like to share that by March 30th we will have a full report of primary care access in the State of New York, a county-level-wide analysis of data of primary care facilities and the access to care that's needed. While we are still finalizing the data in the analysis, we can say that what we've found, as in other studies that have been shown throughout, that people who live in counties with more primary care providers have better health outcomes and longer longevity. And we're very encouraged and excited to share it with you when the report is released on March 30th.

Finally, I also would like to echo that we do hope that the Legislature will reject the $20 million decrease of medical

home incentive payments in the New York State Medicaid program. It takes an average of almost $14,000 per full-time provider to achieve PCMH and an additional average of more than $8600 per provider, full-time provider, annually to maintain it.

We also know that studies show that the longer a practice has been transformed, the overall impact of practice transformation, particularly the cost savings, is increased. We very much urge the Legislature to help protect the PCMH incentive program.

Thank you.

CHAIRWOMAN YOUNG: Great.

MR. KWAN: Thank you, Senator.

CHAIRWOMAN YOUNG: Any questions?

Thank you very much. Thanks for filling in.

Our next speaker is Executive Director Bryan O'Malley, Consumer Directed Personal Assistance Association of New York State.

Thank you for being here.

MR. O'MALLEY: Thank you very much.

And thank you for putting in so much time. I think it has -- it's been a long day.

We had about 450 individuals with disabilities, workers and others here in Albany today. You can see my shirt, left over from Lobby Day.

I'm here to talk about much of what I'm going to tell you tonight, and primarily that is despite the fact that consumer-directed personal assistance is probably one of the fastest-growing industries in the State of New York -- we have added about 15,000 consumers to this program over the past five years. That's about 25,000 new workers around the State of New York -- we do find ourselves in the state of a workforce crisis throughout the state.

Consumers who utilize this program cannot find staff. And if it weren't for the fact that one-third or so of the consumers who utilize this program are able to utilize family, the crisis would be that much more dire.

Last year we conducted a study and we

were able to determine that it took -- for 20 percent of the consumers who are in this program, it took them over six months to find a staff person to perform the services they needed to survive every day. For about 8 percent of those consumers, it took them over a year to find somebody to perform those services.

These are critical home care services that are as basic as getting out of bed and going to the bathroom. They're things that all of us take for granted every day.

The origination of this crisis is simple. We have taken a job that used to pay about 150 percent of the minimum wage and turned it into a minimum-wage job. This job -- and let's be clear, this is not a minimum-wage job at Burger King levels or Walmart levels. We are making $1.10 to $1.50 less than other minimum-wage sectors in the economy.

When confronted with those two choices, for how to go to work and earn a living every day, it takes a very special

person to sign up for this work.

The wage structure is broken not because FIs are greedy -- they're not saving money, many of the FIs are losing money themselves. Many of them are going out of business. Our fee-for-service system is broken, as many of you have heard today. The direct care ceiling has not been raised in 10 years. That has resulted in costs where providers are already losing a nickel to a dime per hour.

As the minimum wage increases, the rate is being funneled back into those direct care costs, and it is being foisted on providers. So where the Department of Health does initially fund it in Year 1 and Year 2, as we move further out, it is being foisted on providers and that money is leaving the system.

The managed-care system is broken. In New York City, providers are required to pay $17.09 an hour in wages and benefits. Fidelis is paying those FIs $17.70 per hour. That leaves 61 cents for workers'

compensation, unemployment, payroll taxes, billing, administrative expenses, MTA tax, and more. You cannot run a business on 61 cents.

This is the state of the home care industry. This is the state of CDPA. This is what is creating the crisis. If we don't do something about it, people will wind up in nursing homes, people will die. It is that simple.

I also wanted to spend 30 seconds talking briefly about the proposed marketing and referral ban. We were flat-out told by the Department of Health that they wish to institute a marketing and referral ban because people are seeing advertisements for consumer direction, they are signing up for MLTC, and they would like to see that stop. In other words, people are finding out about a Medicaid service they qualify for that improves their quality of life, and the Department of Health would prefer that didn't happen because it is hurting the Medicaid budget's bottom line and the global cap.

We find that intolerable, and a backdoor benefit cut. It is politically unpopular to cut the consumer-directed program, so they would rather people just not know about it.

I will just note we would like rejection of the six-month -- the rejection of moving people out of MLTC after six months in a nursing home, rejection of the proposal on the UAS score of 9, and a rejection of the proposal to require 12-month continuous care within one MLTC as well.

Thank you very much.

CHAIRWOMAN YOUNG: Thank you, Bryan.

Any questions? Thank you. Right on the dot.

CHAIRWOMAN WEINSTEIN: Thank you.

CHAIRWOMAN YOUNG: Thank you.

Next, we have Government Relations Director Julie Hart, from the American Cancer Society Cancer Action Network.

I think I saw you in the hallway about eight hours ago.

(Laughter.)

MS. HART: Thank you for the opportunity to testify today. I appreciate it very much.

You have a copy of my written testimony which shows you what the cancer burden is in New York State. We have overall, in terms of new diagnoses expected in 2018, we expect about 110,000 people are going to receive a cancer diagnosis this year and we'll see about 35,000 deaths from cancer this year across the state.

I have broken it down by selected cancers. The blue chart shows diagnosis for 2018 by select cancers. And then the red chart on page 2, you'll see expected number of deaths, again, by select cancers there.

So I just want to highlight a couple of areas very quickly. The first relates to tobacco use.

This is an area where New York -- traditionally, we've really been a leader when it comes to tobacco control. Our adult smoking rate is 14.2 percent. That's the ninth-lowest in the country. Our youth

smoking rate is 4.3 percent, that is the lowest in the nation, and that is thanks to the works that you guys have been doing. We have a strong Clean Indoor Air Act, we have a high cigarette tax, and we have a great although underfunded tobacco control program.

So we've made great progress when it comes to our high school smoking rate. That's very encouraging. Now, what's not as encouraging is if we look at overall tobacco use with kids.

So when we take in all of those other products, the overall high school use rate is about 25 percent, which is astonishing. And it's actually increased since 2010. Now, that's not surprising given that these are the products that they can be flavored, they're enticing to kids, and there's also a price difference there. When it costs $10 or $11 to get a pack of cigarettes but you can get flavored cigars, two for $1.99 -- these products are cheaper, so these are the ones that kids are going to gravitate to.

Same with e-cigarettes. Price varies

considerably and, again, you'll see a significant amount of flavoring -- anything from grape to peanut butter and jelly -- and these are things that really are appealing and enticing to kids.

Now the Governor has proposed a tax on e-cigarettes in his budget. We support that in concept, but we do have concerns with the way he has structured this and we do think that you need to reconsider and, instead of creating a whole new tax on this, tax these cigarettes like you tax other tobacco products, based on wholesale price.

The proposal in the Executive Budget taxes by milliliter fluid, and therefore you wouldn't see an increase as the wholesale price increases if you do that. And what could be more problematic is that, you know, say if the industry turns around -- this is a very stealthy industry -- if they turn around and just increase the concentrations of the fluid so they can undermine the tax that way.

So we would encourage you to look at the e-cigarette cigarette tax, but in a

different way so that it's structured the same as other tobacco products.

As far as the tax on other tobacco products, we have not seen it increase in those products since 2010. And again, we're not seeing the same progress that we're seeing with cigarettes there, so this is another area where we would strongly encourage you to increase the tax on those tobacco products so that we have parity with cigarettes, so that we again can keep kids from ever starting to use these products.

If you increase the tax on other tobacco products to provide tax parity, you'd have to increase from 75 percent of wholesale price to 97 percent of wholesale price. And we estimate that that would also bring in $25 million in additional revenue. And this again is outside of the Governor's projection for e-cigarettes.

So we hope that you will consider that, and when we strongly urge you to consider that -- because there really is a public health need to look at this policy

approach and to increase the price there -- we would also encourage that some of that money go back to the state's tobacco control program so that hopefully we can keep more kids from beginning this addiction and help smokers that need assistance with their addiction.

In addition, I wanted to talk very briefly about the state's Cancer Services Program. We are very fortunate that we do have an excellent Cancer Services Program across the state. The Executive Budget proposes flat funding for the program at a little over $19 million. However, the program received a $5.4 million cut in the current fiscal year, so that has impacted legal services, breast cancer support groups, and then, most notably, clinical services -- the actual screening. So fewer screenings are being done because contractors are running out of money at this point.

In one case, there was a contractor that gave me a call, they said they could no longer screen for colorectal cancer. They

couldn't give them the FIT kit -- which is the home-based kit, which is the least-expensive option -- because they couldn't afford the colonoscopy that followed that. So we would urge you to restore funding on that.

And then just very quickly, two issues that the Governor's budget does not touch on. HPV vaccine, this is an area on page 6, I actually have what the vaccination rates are for New York State for children ages 13 to 17 there. Again, very low HPV vaccine, it's a cancer vaccine, and we want that conversation with the provider and with parents to be about cancer. This is not about STDs. We need to do education there, so we're asking for $500,000 so that we can increase those vaccination rates.

And then childhood cancer research and treatment, about 1,000 kids each year are diagnosed with cancer across the state. Diagnosis and risk factors for childhood cancer are very different than they are for adults, treatment options are very different

than they are for adults, so very heartbreaking for those families. So we would encourage the state to look at putting in some additional funds for research and treatment.

Thank you.

CHAIRWOMAN YOUNG: Thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

CHAIRWOMAN YOUNG: Our next speaker is New York Policy Manager Allison Cook, Paraprofessional Health Institute.

After that, we've got the manager of government affairs, Dr. Greg Beratan, Center for Disability Rights. Is he here? Okay, speeding right along.

(Discussion off the record.)

CHAIRWOMAN YOUNG: Okay. After that we've got Dr. James McGuirk, Ph.D., CEO, Astor Services for Children & Families. He's here.

Welcome. Thanks for being here.

DR. McGUIRK: Thank you very much for hanging around and listening to our request.

I am also the president of the

New York State Coalition for Children's Behavioral Health. You heard from Andrea a little bit earlier. I'm here to talk specifically about the RTFs.

The RTFs are a relatively small program in the scope of all the state's mental health programs, and if you read my testimony you'll see some of the profiles of the kids that we serve. And you'll notice that they're young kids from the ages of 5 to 21. They have very serious emotional and behavioral challenges that really create significant stress on families and on communities. And for these kids, the RTF is a godsend and a safety net provider.

And what we're here to talk about is the role of the RTF in this new transformation. And we've been working very closely with the Office of Mental Health and the Department of Health to really find a place for RTFs within the new Medicaid redesign service system. And what's been clear to us is that the monies available to the behavioral health providers, and RTFs

specifically, have been minimal. And as a result, it's putting the entire system at risk.

And so what we're asking for specifically is capital, because we need to transform our environments to make sure they can safely provide the care and treatment for these very challenging children. Most of the RTFs were created at a time when they were in residential treatment centers, so these had been old residential units that have been converted and they no longer meet the needs of the populations that we're serving. And so making sure that we have the capital to be able to renovate and rebuild our programs is critical.

And an important part of that is debt relief. Astor has been fortunate that we have the ability -- we had the ability due to OMH to build a brand-new facility, and it's gorgeous and it meets the needs of the kids. However, in this changing environment we are not confident that our debt will be paid for throughout the life of our loan, because at

some point, as the managed-care companies are the ones that will be paying, that we're not sure that they will pay for the debt service, number one. And number two, the flexibility that we're being asked to consider really requires us to think about different models besides an RTF model.

And so debt relief allows us to have the flexibility to really work more closely with the Office of Mental Health to design a program that meets the needs of this new environment. And so that becomes very important.

Now, why are we here in this committee? There have been hundreds of millions of dollars set aside for healthcare transformation for hospitals and community-based providers. The RTFs have not had access to those dollars and that money, and we think that's unfair. We think it really disadvantages us as an important provider for some very difficult kids, and we ask that you create a separate pool specifically for these RTFs.

So with that, I say thank you very much. Are there any questions?

CHAIRWOMAN YOUNG: Questions?

Yes, Mr. Cahill.

ASSEMBLYMAN CAHILL: It's not a question. But Jim, thank you for coming up. Your facility, the Astor Home, serves children in my community but from communities all over New York State. I know there's some from the speaker's community, some from the majority leader's community on Long Island.

And I just wanted to point out from our previous conversations that this building program that you embarked on was absolutely necessary. Compared to the -- I looked at the old facilities versus the new, and I don't know whether it would have made sense if you didn't think you could rely on funding, and things have changed dramatically since you made that building.

So in addition to the fact that it's just a good idea because it's a good idea, it's also a good idea that we keep our word and that we make sure you have an adequate

funding stream to support those improvements.

DR. McGUIRK: And it puts our agency at risk, not just the RTF program.

CHAIRWOMAN YOUNG: Senator Hannon has a question.

SENATOR HANNON: I understand the shortcomings of -- the frustration of not getting in the capital program. That's the Governor's choice that we have to address.

But you also mentioned that it's getting referrals, necessarily, from private insurance. Where else would they refer if not to one of the RTFs in New York?

DR. MCGUIRK: Out of state.

SENATOR HANNON: So that's the alternate that's going on right now?

DR. McGUIRK: Yes. Yes.

SENATOR HANNON: And we have actually worked to try to bring people back into the state.

DR. McGUIRK: That is correct.

SENATOR HANNON: Thank you.

CHAIRWOMAN YOUNG: Thank you.

DR. McGUIRK: Thank you very much.

CHAIRWOMAN YOUNG: The next speaker is Executive Director Tim Hathaway, from Prevent Child Abuse New York.

MR. HATHAWAY: Good evening, members of the committee. Thank you very much for the chance to speak with you this evening.

Prevent Child Abuse is an organization working statewide really doing three things: Policy advocacy work, professional development and training at a community level across the state, and then on the issue of changing the narrative about issues related to child maltreatment.

So there are really three things that come for the issue of health. Child maltreatment really is a public health issue. It impacts hundreds of thousands of children in the State of New York every year, costing the state millions and millions of dollars.

Three things that there's been a little bit of discussion about today. The first one is the issue of early childhood home visiting programs. So maternal/infant early childhood programs fall under the

auspices of the Health Department. It's a federal program, but it's serving a lot of kids across the State of New York. So we are disappointed to see that the Governor's budget does not include as much increase around this issue as we know is important.

When we talk about programs that work, home visiting works -- reductions of up to 50 percent in terms of child maltreatment. So if we could cut the number of kids being abused by 50 percent by supplying these front-end preventative services, we'd be in much better shape. So I would encourage you to reexamine this work.

There is a proposal for about $200,000, a little drop in the bucket, to really build infrastructure around the workforce. These programs -- again, you have heard a lot of testimony about direct service folks. The people working in these programs really will benefit from workforce development efforts.

The second issue I'd like to speak with you about is the Comprehensive

Contraceptive Care Act. So why is this important in terms of child maltreatment? We believe very strongly there's good evidence that when women and families have more and better access to family planning, they have better outcomes in terms of kids. It reduces risk, reduces stress for families, creates opportunities for people to be thoughtful about how they're bringing children into the world and the options that they have to care for children. We appreciate the fact that safeguarding reproductive health for women is an important issue in terms of creating the sort of environment where families thrive.

The third issue is related to relationship and sexuality education for all children. This again is a very important public health issue. When children have better information about relationship health and about sexuality health, they are inoculated against sexual abuse.

Sexual abuse is something that we're hearing a lot about in our communities, in our national news. We're hearing a lot about

how we can protect kids very simply by helping them, equipping them early throughout their growing and formative years. So I would encourage you to really examine the proposals, the proposals that are out there relative to that work. They're critical to the health of our children.

With that I will say thank you, and I hope you have a great rest of the evening.

CHAIRWOMAN YOUNG: Thank you so much.

SENATOR HANNON: Thank you very much.

CHAIRWOMAN YOUNG: Our next speaker is Executive Director Steven Sanders, Agencies for Children's Therapy Services, ACTS.

Welcome back, Steven.

MR. SANDERS: Good evening. Thank you all for still being here at this late hour. I heard there were some people who were going to start their testimony by saying "good morning," and they were worried that they might have to start their testimony by saying "good morning." But I don't think it will be that long.

Yes, my name is Steven Sanders, I am

the executive director of Agencies for Children's Therapy Services. The agencies that belong to my association provide a majority of the early intervention services across the state each year. In the interests of time, I'm just going to try to address three points and do it very quickly, three points from the Governor's proposals.

The Governor once again is proposing to drastically change, reduce, and condense the evaluations, which is the starting point for children to be identified who may have learning disabilities and developmental disabilities. He wants to change it in such a way that fewer evaluations will be done. There will not be any assurety that multidisciplinary evaluations will any longer be done, and that is key to the program because there are a lot of disabilities and problems that youngsters have that are subtle or not that obvious, and you need a rigorous multidisciplinary evaluation system to identify all those issues that kids have.

When you get rid of that, you run the

risk of kids not being identified or being underidentified. And the result of that does not save the state any money, if that's what the Governor's intent is, but rather it delays the identification of these problems and it becomes a much bigger problem and a much more expensive problem for special education and preschool special education programs. So I encourage you to reject that proposal, as you have done in the past.

The second point I want to address is something that I think is a good idea that the Governor has proposed. The primary reason why commercial insurance rejects claims -- and they reject about 85 percent, almost 85 percent of the early intervention claims that they receive each year. That number has remained consistent for virtually the entire 25 years of the program. The primary reason why they reject claims is because of a lack of prior authorization, by their definition of what prior authorization should be.

What the Governor is suggesting is to

make the individual family service plan or a doctor's script, both of which are required before services can begin in early intervention, to make that doctor's script, that IFSP, tantamount to prior authorization.

If you make that change in the insurance law, then commercial insurance companies will have one less reason to reject claims. If they reject fewer claims, that means there will be more money coming from the insurance space, which means there will be less money coming from the state and counties to reimburse providers.

So commercial insurance clearly does not pay their fair share. Clearly. And this is a change that I think would be a welcome change and one that I think you ought to embrace.

Finally, the Governor is proposing that all denials of claims, all denials of claims -- commercial insurance, Medicaid -- must be appealed. To appeal all claims, number one, really doesn't guarantee there will be a different outcome at the end, but,

number two, will add more layers of work, more layers of cost, more layers of time-consuming administrative work which providers have already had layered upon them. And it will delay reimbursement to providers by weeks, probably months.

It's not a good idea. It's not going to lead to greater reimbursement, in all likelihood. What it will lead to is greater expense for providers and greater time.

So I hope that you will reject that claim and simply embrace a proposal that providers receive a clean 2 percent rate increase, a rate they haven't seen in 16 years.

So with that, I've just about made it, and I thank you so much for your time.

CHAIRWOMAN YOUNG: That's great.

Senator Krueger has a question.

SENATOR KRUEGER: Evening, Steve.

So you come here every year to testify, and it does seem that there's just some fundamental fight with the administration every year over whether early

intervention costs the state more money or saves money, and I know you testify every year that it saves money.

Are there some studies that have been done that actually we can wave around showing if we invest in quality early intervention we're actually saving the state money? Because I think that helps you win.

MR. SANDERS: Yes. There are several authoritative studies -- I'm not sure if they originated in New York State or not, but the studies all agree that when a child who should receive early intervention services does not, it will cost the state, whatever state we're talking about, approximately seven times that amount of money by virtue of the fact that there will be delayed services required in special education -- preschool special ed, special education, and beyond.

Because, you know, I think one thing which is a given -- I'll say this really fast -- one thing which is a given is that the earlier that you try to remediate disabilities, the easier it is and the more

successful you will be.

So when you wait an additional two or three years once that child gets into a school-age situation or later, it's going to cost a lot more money for the state and counties. Seven times seems to be the number that has been embraced by most of the studies that I've seen. I'll try to find you one or two of those studies.

SENATOR KRUEGER: Thank you.

MR. SANDERS: Okay.

CHAIRWOMAN YOUNG: Thank you.

MR. SANDERS: Thank you all. Thanks very much.

ASSEMBLYMAN CAHILL: Very briefly, on this question of providers filing appeals. What kind of charges does a per-visit get that would have to be appealed? My recollection is that many of the providers who are providing services in early intervention are getting $25, $35, $45, $50 for their service. And that's what is being proposed, that we require an appeal on top of, already, the bill collecting that they

have to do?

MR. SANDERS: Yeah. There are a range of services, the most expensive being probably in the autism area and ABA, applied behavioral services. Those are the most expensive.

But you're correct, there are a lot of services, especially evaluations, which are $25 or $30 a session. All of these denials would have to be appealed. Tens of thousands of denials would now have to be appealed. It's going to take time, it's going to take much more expense, more administrative work, with very little additional return.

ASSEMBLYMAN CAHILL: Thanks, Steve.

MR. SANDERS: Thank you very much. Thank you all very much.

CHAIRWOMAN YOUNG: Thank you.

Our next speaker is the director of the health law unit, Rebecca Novick, Legal Aid Society.

Welcome.

MS. NOVICK: Thank you for the

opportunity to testify this evening. My name is Rebecca Antar 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 health care consumers from all five boroughs of New York City. We are very grateful that overall the Executive Budget maintains the strength and integrity of New York's Medicaid program, especially in the face of persistent threats from the federal government to Medicaid and the health care system as a whole. We are confident that New York will continue to be a leader in providing high-quality comprehensive health care in the Medicaid program.

As the program continues to implement sweeping changes to programs and products, it

is particularly important to protect low-income New Yorkers' access to quality benefits and services. I'm going to briefly comment on just a few of the issues that I discuss in my written testimony.

First, we oppose the managed long-term care 12-month lock-in because it takes away an important way for members to assert their rights. Though there is a similar lock-in provision in mainstream managed care, the grace period in the mainstream program is 90 days, versus 30 or 45 in this proposal. And it would be unreasonable to impose a more stringent requirement on a population by definition that has more extensive needs.

In addition, mainstream beneficiaries eligible for health and recovery plans or for special needs plans are able to switch into one of those programs at any time. This recognition of the importance of flexibility for high-needs individuals should get preserved in MLTC.

Unfortunately, we have observed serious information gaps about the services

available through plans and the likelihood of getting them and other failures of case management in MLTC.

Of course, we hope that all MLTC members are able to reach an advocate or avail themselves of the dispute resolution options. But too often when a client gets to us, we find out that for months or sometimes years they've been attempting unsuccessfully to even request additional services from their plan. And sometimes we hear that they've heard from a neighbor or a friend about a plan that is actually serving them very well, and even with outreaching an advocate they're able to get to another plan and are able to get the services that they really need that way.

I just want to briefly mention, with regard to the nursing home carve-in, because I know it's been discussed a lot today, that from the consumer perspective I just want to emphasize, first of all, how common it is for members to be in a nursing home for six months or more but they want to and are able

to live safely in the community.

And I also just want to emphasize how incredibly difficult it is to get out of a nursing home into the community, especially when you've been there for a long time, and how much more difficult it was before the carve-in, and we really fear going back to that time. Making the stars align just doesn't even begin to describe the amount of coordination that needs to happen to get somebody into MLTC and into the community.

I want to strongly support the $2.5 million appropriation for the Community Health Advocates program in the Executive Budget, and urge the Legislature to provide an additional $2.25 million to fortify and expand this critical program, as well as $2 million to revive the Small Business Assistance Program.

We are proud to serve as a specialist organization in the CHA network, which has served more than 300,000 New Yorkers with every kind of health insurance since 2010. In the face of so much uncertainty about the

ACA and the Medicaid program, our role in providing consumer assistance is more important than ever.

In my last few moments I just want to comment on -- really briefly -- on a couple other access-to-care things. First of all, we strongly oppose the increased copayment for over-the-counter medication. Our clients do not have additional money to pay, and too often it really does happen that even though they shouldn't be, they're turned away from the pharmacy without getting their drugs.

I really want to emphasize the importance of reminding plans and consumers and pharmacies about the fact that people cannot be denied a drug without their copayment, but the fact is that it happens and it happens more when copayments are higher.

I also want to support the increase in the physical therapy cap from 20 to 40 visits, but I want to say that really there should be no cap at all. This should be aligned with the requirement in Medicaid as a

whole that there is a medical necessity standard, and people should be getting the services that are necessary for them.

Thank you very much.

CHAIRWOMAN WEINSTEIN: Thank you.

CHAIRWOMAN YOUNG: On the dot.

Thank you.

SENATOR KRUEGER: Thank you.

CHAIRWOMAN YOUNG: Our next speaker is Charles King, president and CEO of Housing Works.

MR. KING: I've been threatened by one of the senators but --

(Laughter.)

ASSEMBLYMAN CAHILL: Let's make it unanimous for both houses.

MR. KING: I was here before all of you this morning, and I will be here until you're ready to leave. So bear with me.

SENATOR HANNON: Let the record show you're just being jocular.

MR. KING: There you go.

So first of all, I want to share with you some very good news, and that is that if

you look at the 2016 surveillance data for HIV, New York State is well on track to ending AIDS as an epidemic by 2020, as the Governor committed in 2014. And as somebody who's been riding herd on top of this process, I can't tell you how proud we are that we have gotten this far along.

However, I do want to point out that there is a growing disparity in the progress we're making in New York City versus the progress we're making in the rest of the state. And one singular difference between New York City and the rest of the state has to do with housing for people living with HIV. Through the 30 percent rent cap approved in the budget two years ago, through -- three years ago, through action by the Governor, two years ago they changed the definition of HIV disease. Now New York City is the one jurisdiction anywhere in the entire world where low-income people living with HIV are guaranteed housing through enhanced rental assistance or through supportive housing.

That same benefit does not apply to the rest of the state, neither the 30 percent rent cap nor an enhancement sufficient for anyone to get a decent apartment. As a consequence, there are some 28,000 people in New York City taking advantage of this benefit and 72 households taking advantage of this benefit in the entire rest of the state.

We tried to fix it this year. Being judicious with my words, I would say that the Division of the Budget was inartful at best in how it worded the changes. We are working to get it corrected in the 30-day amendments, but failing that, we are definitely going to need the support of both houses.

It is fundamentally unfair that someone living in Rochester, in Westchester, on Long Island or anywhere else in this state does not have the same benefit that people living with HIV are afforded in New York.

And by the way, that could be funded out of Medicaid to the point that Jason answered this morning, inasmuch as Medicaid -- two studies show that housing for

people with HIV accrues up to $15,000 a year in savings just in averted emergency room and inpatient.

And by the way, I don't think anybody's really noticed that a couple of years ago, two years in a row, in your budget you passed legislation that appropriated $44 million in Medicaid savings under the cap to housing. That money was borrowed by DOB to help pay for the federal government's recruitment and was to be paid back this year. That money was not restored to OHIP, and that money in and of itself could pay the cost of this expansion for several years.

Very quickly, the other things that I just want to comment on. The Governor announced December a year ago a commitment to end AIDS mortality -- that is, death associated with AIDS -- by 2020 and to end HIV transmission among people who use drugs by 2020. Workgroups came forward with proposals to do that using the same sentinel-events methodology that we've used to get to near-zero perinatal transmission.

It would only cost $3 million a year to implement this methodology.

The Governor has not included this money in his budget. Before I fault him, I should say that since we began this effort to end AIDS as an epidemic, neither the Assembly nor the Senate has put forward any contribution other than approving what the Governor put in his budget, so I would urge you this year to put the $3 million in so that we can eliminate AIDS mortality and eliminate transmission through injection drug use, which we now already have down below 120 cases a year. It's an amazing, phenomenal accomplishment that no other state can claim.

Very quickly, to drug user health. I just want to point out that Dr. Zucker evaded a question that he was asked this morning. The AIDS Institute has received $300,000 a year from naloxone -- no increase now for over three years. If we want to stop opioid overdoses, we need to make it happen.

We also need to invest in other forms of drug user health, and that includes

supervised injection facilities. I was gratified to hear what Jason said today about hepatitis C and negotiating for rebates, but we do need money to establish competent provider networks around the state. We can do it, we can eliminate hepatitis C in this state, we could be the first state to eliminate hepatitis C., even though we now have 150,000 or more people living with it. But we need the resources to begin to build a campaign to make that happen.

And last but not least, I want to echo the testimony that you've heard about the public health campaign dollars. TB across the state was cut from this pot of money by 20 percent last year, and what is envisioned this year is an additional decrease of 20 percent in funding when we now have TB actually on the rise, including new cases of multidrug-resistant TB.

And then one last point and I'll be done, and that is that Health Home has been critical to ending the AIDS epidemic and is critical to eliminating hepatitis C and to

drug user health. I urge you not to take the advice of the Plan Association and eliminate or cut any further Health Home.

Thank you so much.

CHAIRWOMAN YOUNG: Thank you, Mr. King. Thank you for being here.

Any questions?

MR. KING: I thought Senator Rivera had one for me.

CHAIRWOMAN YOUNG: He just needed the Heimlich maneuver.

I just want to verify that they're not here -- Planned Parenthood Empire State Acts, Robin Chapelle Golston, was supposed to be here?

CHAIRWOMAN WEINSTEIN: No.

CHAIRWOMAN YOUNG: No, they were invited.

Yes, thank you. Okay, that concludes the Health Budget Hearing, and we'll see everyone tomorrow for Mental Health. Thank you.

(Whereupon, the budget hearing concluded at 8:28 p.m.)