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

JOINT LEGISLATIVE HEARING

In the Matter of the
2019-2020 EXECUTIVE BUDGET
ON HEALTH AND MEDICAID

Hearing Room A
Legislative Office Building
Albany, New York

February 5, 2019
9:36 a.m.

PRESIDING:

Senator Liz Krueger
Chair, Senate Finance Committee

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

PRESENT:

Senator James L. Seward
Senate Finance Committee (RM)

Assemblyman William A. Barclay
Assembly Ways & Means Committee (RM)

Senator Gustavo Rivera
Chair, Senate Committee on Health

Assemblyman Richard N. Gottfried
Chair, Assembly Health Committee

Assemblyman Kevin A. Cahill
Chair, Assembly Committee on Insurance

2019-2020 Executive Budget
Health and Medicaid
2-5-19

PRESENT: (Continued)

Senator Diane J. Savino

Assemblyman Edward C. Braunstein

Assemblyman Nader J. Sayegh

Assemblyman Andrew P. Raia

Assemblyman Phil Steck

Assemblywoman Marjorie Byrnes

Senator Patrick M. Gallivan

Assemblyman Andrew Garbarino

Assemblyman John McDonald

Assemblyman Jake Ashby

Senator Chris Jacobs

Assemblyman Edward P. Ra

Senator Patricia A. Ritchie

Assemblywoman Michaelle Solages

Assemblyman Kevin M. Byrne

Assemblyman Clifford W. Crouch

Assemblywoman Rodneyse Bichotte

Assemblywoman Patricia Fahy

Senator John C. Liu

Assemblyman Simcha Eichenstein

Assemblyman Félix Ortiz

2019-2020 Executive Budget
Health and Medicaid
2-5-19

PRESENT: (Continued)

Senator Susan Serino

Assemblyman Thomas J. Abinanti

Senator Brad Hoylman

Assemblywoman Aileen M. Gunther

Senator Robert E. Antonacci

Senator Jen Metzger

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CHAIRWOMAN KRUEGER: So you'll notice it's quite crowded, and that's because we're in Hearing Room A because Hearing Room B had a multifunction problem. And so we're in Hearing Room A until Hearing Room B gets repaired.

There is also, for people to know -- and they should be told when they come down or across, Hearing Room C, just across the way, is actually set up as sort of supplemental space. And it has a TV screen, and you can watch us on TV if you are in search of more space to spread out.

We are going to be fairly strict about many things today because, one, it was already designed to be the longest budget hearing, based on how many people wanted to come and testify and, two, now because of the added confusion around a smaller hearing room.

So just please know, if you decide to have conversations, I am going to ask the guards to direct you to another space to have those conversations, not in here. I think I

saw some people with placards on their laps. We don't allow the holding up of placards at the hearing. So if you're going to plan on holding up placards, we're also going to ask you to go to Hearing Room C. It's not personal, it's the rules of how we function in these dual Assembly-Senate legislative hearings.

This is the Assembly-Senate Finance-Ways and Means joint hearing on healthcare and the budget. So we're hoping that everybody will keep their testimony focused on things that are either in the budget or things that they think should be in the budget and are not there.

We have a new clock system set up. Everybody can see clocks, including the people testifying. Government representatives will have 10 minutes to present. Everyone else will have five minutes to present. Which means if you bring four people up from your organization, you're still only getting one five-minute period. So decide before you show up at the front

which one of you is speaking.

The legislators, when dealing with the government reps, the chairs of the relevant committees, which are Health, Insurance and Finance for this hearing, will have 10 minutes to ask questions; everyone else will have five minutes. And when I say the time frame, that's for the questions and answers when we get to the legislative asking of questions.

So we urge all testifiers, don't read your testimony unless you timed it out at home and it's exactly five minutes long. You're better off just targeting the key points and raising them. We have received every piece of testimony. It is all publicly available online.

And this is live-streamed, so there are lots of ways for the legislators who are here and the remaining legislators of both houses to review every single testimony submitted. You have till up to seven days after the hearing to submit your hearing or make changes to your testimony.

I'm going to introduce myself. I'm Senator Liz Krueger, Finance chair. And Helene Weinstein, chair of Ways and Means, my partner in these hearings.

Then, going to the Senate introductions first, I see -- so I'm just going to introduce the Democrats now: Senator Brad Hoylman, Senator Gustavo Rivera, Senator Diane Savino. And my colleague also for these hearings, the ranker for Finance, Jim Seward, who will introduce the Republicans.

SENATOR SEWARD: Thank you, Madam Chair. We've been joined this morning by our ranking member on the Health Committee, Senator Gallivan. We have Senator Serino and Senator Jacobs.

CHAIRWOMAN KRUEGER: And Assembly.

CHAIRWOMAN WEINSTEIN: So in the Assembly we have our Health chair, Richard Gottfried. We have our Insurance chair, Kevin Cahill.

I'll be doing the Democratic Assembly members, and Will Barclay, the Republican

ranker on Ways and Means, will be doing the Republican members. Assemblyman Braunstein, Assemblywoman Solages, and Assemblyman Nader Sayegh, one of our newest members.

And then Assemblyman Barclay.

ASSEMBLYMAN BARCLAY: Thanks, Chairwoman. We are joined -- on the Republican side of the aisle, we have our ranker on Health, Andy Raia. We have our ranker on Insurance, Andrew Garbarino. We're joined by Assemblyman Ashby and Assemblywoman Marjorie Byrnes.

Thank you.

CHAIRWOMAN KRUEGER: So if we've covered all the introductions -- and legislators will be coming and going across the course of the day, and we will try to introduce them as they come in when we see them. I see Senator Patty Ritchie walking in as I make this speech, so I'm just introducing Senator Ritchie. And there are some seats up here, Senator, I believe.

And our first testifier today is Senator Howard Zucker, who --

(Laughter; cross-talk.)

COMMISSIONER ZUCKER: I've been promoted. Thank you, I'll come up there instead. I'd be happy to ask the questions of the department.

(Laughter.)

SENATOR KRUEGER: You know, we spend a lot of days and nights in these rooms. We haven't had enough sunlight. I think it's a vitamin D deficiency; you might want to recommend something to me. I'm sorry, Dr. Zucker --

COMMISSIONER ZUCKER: Thank you.

CHAIRWOMAN KRUEGER: -- who is the commissioner of the Department of Health for New York State.

COMMISSIONER ZUCKER: Thank you. And good morning, Chairs Krueger and Rivera, Weinstein and Gottfried, and members of the New York State Senate and Assembly. I'm here to present Governor Cuomo's fiscal year 2020 Executive Budget as it relates to health.

I am joined by Donna Frescatore, to my right, the state Medicaid director and

director of the New York State of Health.

You have before you a comprehensive written testimony, and I'll be delivering an abbreviated version this morning.

In his State of the State address, the Governor outlined a justice agenda that rests squarely on the foundation of FDR's four freedoms: Freedom of speech, freedom of worship, freedom from want, and freedom from fear. The health-related proposals in the Governor's Executive Budget apply to these latter two freedoms. No New Yorker should want for the basic necessities to live a healthy life, and no New Yorker should live in fear that his or her access to a healthy life will be taken away.

The Governor believes that healthcare is a basic human right. And while the federal government seems to be working to increase fear and want in relation to healthcare, the Governor is setting out to protect New Yorkers.

Let me give you a little bit about the progress to date. We have made tremendous

progress in expanding access to healthcare across New York State. More New Yorkers than ever before have access to high-quality, affordable health insurance. New York's Medicaid program serves over 6 million members. New HIV diagnoses continue to drop to record low levels. The department has launched the NYS Health Connector, powered by the all-payer database, and this web-based application makes a wide range of health information, including the cost of medical procedures and how frequently these procedures are performed, easily available to all New Yorkers. And in 2018, the Commonwealth Fund's Scorecard of Health System Performance ranked New York as the most improved in the nation.

Despite this success, we face an unprecedented assault from Washington. I realize I used the very same words in addressing you last year, but the fact is the attacks have escalated. The Governor and this agency remain undeterred amid a barrage of assaults on the freedoms that FDR

championed. We've seen ongoing attempts to tear down the Affordable Care Act, placing at risk the healthcare of millions of New Yorkers, along with billions of dollars in federal Medicaid funding. We've seen efforts to roll back protections for women's reproductive health and for environmental health.

And in response to these threats, Governor Cuomo's Executive Budget proposes to do several things: To enshrine in state law key provisions of the Affordable Care Act; to codify the New York State of Health; to protect our youth from tobacco and e-cigarettes; to provide an additional $2.5 billion to protect our water; to establish a commission comprised of national experts to develop options for achieving universal access to high-quality, affordable healthcare in New York; and to codify Roe v. Wade and protect access to contraception, proposals the Legislature has already passed and the Governor has signed into law.

We will continue to expand access to

healthcare across the state as we address head-on the major health challenges facing our communities.

Let me give you a little bit about the activities this past year. The workforce that allows the New York State Department of Health to deliver on our mission to protect the health of New York may be the agency's most valuable asset. Since 1901, the department has prioritized recruiting a dedicated staff to protect, improve and to promote the health, the well-being and the productivity of New Yorkers.

We have been incredibly busy since I sat here with you last year. Among numerous activities we have -- and I'm going to give you a list of some of the things we have done.

One, we have hosted a successful Aging Innovation Challenge that highlighted breakthrough solutions in independent living for older adults and their caregivers.

Two, we've received recommendations from the Drinking Water Quality Council for

the most protective MCLs in the nation for PFOA, PFOS, and 1,4-dioxane. All three contaminants have been detected in drinking water systems all across the country, yet they remain unregulated by the United States Environmental Protection Agency, which is responsible for setting regulatory limits under the federal Safe Drinking Water Act.

Number three, we're managed one of the most significant flu seasons in recent history, and under the Governor's leadership we enhanced access to flu vaccine for children in pharmacies, engaged in a massive public awareness campaign, and developed the new online Flu Tracker to give New Yorkers the county-level information they need about flu.

Number four, we've convened a workgroup and conducted listening sessions on the devastating, unjust issue of maternal mortality.

Five, we've worked with communities to address harmful algal blooms.

Six, we've expanded Medicaid coverage

of telehealth services to enhance access to care.

Seven, we've worked aggressively to convert Medicaid managed-care payments from volume-based to value-based.

Eight, we began the statewide rollout of e-WIC, a new electronic benefit transfer card that simplifies the shopping experiences of WIC families and retailers.

Number nine, we've enabled a record number of New Yorkers to enroll in high-quality health insurance options through the New York State of Health.

Ten, we've battled the opioid epidemic by placing limits on prescribing while expanding education, particularly among at-risk populations, and increasing access to Naloxone and Medication Assisted Treatment, now known more as Medication for Addiction Treatment.

Number 11, and we are continuing to manage a major measles outbreak that began in the fall, the largest in the state since the 1980s, by working closely with the health

departments in Rockland and Orange counties, in New York City, as well as in Western New York.

And lastly, No. 12, I must mention that Governor Cuomo has identified the campus of Albany's Harriman State Office Building as the future site of the redesigned state public health lab. We anticipate that this new lab for the 21st century will function as a magnet for additional private-sector investments and public-private partnerships.

These are just a fraction of the health initiatives that our talented DOH staff have been engaged in during the past year.

On the issue of lead, lead poisoning in children is caused by swallowing lead or lead dust and can harm a young child's growth, behavior and their ability to learn. The Governor's Executive Budget includes a proposal to require public health and environmental interventions when a child's blood level is 5 micrograms per deciliter. Additionally, I will establish minimum

standards for maintaining lead-based paint that may exist in rental properties across the state and empower local housing code officials to integrate these standards within existing enforcement to prevent lead poisoning from occurring in the first place.

On tobacco and e-cigarettes, the Governor is taking another important step towards safeguarding the health of youth and vulnerable populations with the Executive Budget's proposal to institute greater controls on the use of tobacco and e-cigarettes.

This extraordinarily comprehensive package will, one, raise the minimal sales age of tobacco and e-cigarette products to 21; two, prohibit sales of tobacco and e-cigarette products in pharmacies; number three, prohibit discount coupons or rebates provided by tobacco and e-cigarette manufacturers and retailers; four, clarify that the Department of Health has the authority to ban the sale of certain flavored e-cigarette vapor liquid; number five,

prohibit the display of tobacco and e-cigarettes in stores; six, require that e-cigarettes be sold only through licensed retailers; seven, introduce a tax on vapor liquid used in e-cigarettes; and number eight, prohibit smoking inside and on the grounds of all hospitals licensed and operated by the New York State Office of Mental Health.

On the issue of toxic chemical disclosures, the Department of Health will work with the Department of Environmental Conservation to ensure that New Yorkers are aware of what chemicals are in the products they use. The Executive Budget includes a proposal to require manufacturers of personal-care products sold in New York State to disclose information related to the health effects of chemicals in their products to help consumers select personal-care products with health and safety in mind.

On Early Intervention, the Executive Budget proposes to increase provider rates to support the provision of Early Intervention

services. And we will increase the rate by 5 percent for services provided by licensed physical therapists, occupational therapists, and speech language pathologists.

On the issue of maternal mortality, building on our work this past year with the Task Force on Maternal Mortality and Disparate Racial Outcomes, the Executive Budget includes $4 million to address key issues. We will create a statewide maternity mortality review board, launch an education and training program to reduce implicit racial bias in the delivery of healthcare, expand and enhance community worker programs, and build a data warehouse to provide essential information on maternal mortality and morbidity.

On opioid proposals, the opioid epidemic remains a major focus for Governor Cuomo. His Executive Budget outlines additional actions we can take to combat this deadly threat. In partnership with several state agencies, the Department of Health will expand ongoing efforts to identify people

living with opioid use disorder whenever they engage with a hospital, and link them to treatment. And we will work to support clinicians prescribing medication for addiction treatment.

On the PBMs, we are also proposing to require that pharmacy benefit managers adopt a transparent model to shine a light into the black box of transactions that occur in this industry.

These are just some of the proposals in Governor Cuomo's Executive Budget as it relates to New Yorkers' health. With these measures, the Governor and the Department of Health will continue our work to improve public health so that all New Yorkers can realize those four freedoms necessary for a strong democracy.

Thank you for the opportunity to share this information, and we're happy to take your questions. Thank you very much.

CHAIRWOMAN KRUEGER: Thank you, Dr. Zucker.

The first questioner will be Chair of

Senate Health Gustavo Rivera.

SENATOR RIVERA: Good morning, Commissioner. There are probably a couple of different rounds, so I'll just get right into it and I'm sure that my colleagues will pick up if I leave anything behind.

First let's talk about the Healthcare Facilities Transformation Fund. Obviously it was a very timely announcement that we got last night, right before this hearing. I haven't had the chance to go deep into it, but I was going to have a series of questions related to Round 2 and Round 3 funding. So I just wanted for -- I'm not going to go into particular institutions that have received or not received or what have you. But I just want, for the record, what is the administration's position on the third round of funding that is made available in the budget now and the institutions that have in Round 1 and Round 2 -- or maybe just in Round 2, but however haven't received funding.

COMMISSIONER ZUCKER: Sure.

SENATOR RIVERA: What is the

Governor's position on that, or the administration's position?

COMMISSIONER ZUCKER: Sure. The additional -- we released the monies and the information this morning. Those who did not receive a grant at this point, we will have another round coming. And at that point those who had applied this time and were unsuccessful, we will keep those applications in place so that we will look at those again. There was a lot of requests for a lot of resources this time, and obviously there's only so much we can get out there.

SENATOR RIVERA: So just for the record, and I'm not sure how many applications there were, but let's say there were a hundred applications, right? And in the current allocation, the ones that were announced today, let's say there were 50 of them. So the 50 applications that did not receive funding, they will be considered already for the third round automatically, is that what you're saying?

COMMISSIONER ZUCKER: Correct. As

long as they want to continue in the process, yes, we will keep those applications. We won't ask them to resubmit another whole application at that point.

SENATOR RIVERA: Okay. We'll definitely have -- I'll have more follow-up with you and your office later, but that's obviously important for institutions all across the state --

COMMISSIONER ZUCKER: I completely understand that.

SENATOR RIVERA: -- and certainly in the Bronx.

Second, I want to talk a little bit about the Fidelis-Centene money and then -- there's all sorts of rumors floating around. So again, for the record, I want to know if the administration has any position on where that -- of how the money is going to be distributed. If you could share that with us, please.

MEDICAID DIRECTOR FRESCATORE: Good morning, Senator.

SENATOR RIVERA: Good morning, ma'am.

MEDICAID DIRECTOR FRESCATORE: At this point the distribution of the transformation fund proceeds, or a portion of them, has been for an across-the-board increase for inpatient hospital --

SENATOR RIVERA: Can you bring the microphone a little bit closer? Not that much, but just a little bit.

MEDICAID DIRECTOR FRESCATORE: -- inpatient hospital rates and for nursing homes. As you know, these healthcare facilities have not received trend increases in many, many years.

The increase was 2 percent across the board for all hospitals and 1.5 percent for all nursing homes in the state. It's 785 facilities in total. Hospitals will receive about $801 million, and nursing homes will receive about 552 million between November of 2018 -- so just a couple of months ago -- and April of 2022.

SENATOR RIVERA: Okay. And so to follow up on that, related to another proposal in the budget which obviously

impacts nursing homes in particular, I really want to understand this nursing home case mix thing, for lack of a better term. It seems to me that it is -- please explain to me how this makes sense, considering that it is a double whack, it's not just a 128 -- 20 million, whatever, savings, it's a $245 million cut to institutions, both for-profit and nonprofit, that are serving the most vulnerable.

So could you explain to me how this makes sense, please?

MEDICAID DIRECTOR FRESCATORE: Certainly. So first let me start by saying that Public Health Law requires the department to make adjustments to nursing homes twice a year. They're made in January and in July of each year to reflect the acuity of a nursing home's residents. Between 2015 and 2018, the case mix adjustment increased by about 52 percent. Total Medicaid spending on nursing homes is about $6 billion a year, and the acuity adjustment accounts for about $1 billion of

it.

These are all numbers, Senator, that include both the state and -- the nonfederal share of Medicaid and the federal funding as well.

Nursing homes are required by federal rules to submit patient acuity assessments within 13 days of a person's admission and then every 92 days thereafter. Under the current method to implement this adjustment, the Department of Health selects one day in each six-month period. That day is the last Wednesday of the month of January and the last Monday of the month of July.

When we look at all of the data submitted to CMS, our federal partners, what we see is variability in assessments during the six-month period. The current method uses only one assessment. So without going into too much detail, if we were to assume, for example, that the date on which the adjustment is currently made is January 31st, the last Wednesday of January, and there was an assessment within that 13-day period and

also in the 92-day period before it, the adjustment uses only the assessment closest to January 31st.

This proposal --

SENATOR RIVERA: I'm sorry to interrupt, but considering that our time -- and I know this is a technical matter, so you're obviously trying to get as --

MEDICAID DIRECTOR FRESCATORE: I was trying to explain the adjustment, yes. So let me just give you the upshot.

SENATOR RIVERA: Please.

MEDICAID DIRECTOR FRESCATORE: Is that helpful, Senator?

SENATOR RIVERA: Yes, that's what I'm looking for.

MEDICAID DIRECTOR FRESCATORE: What this proposal does is it uses all of the assessments during a six-month period to make the adjustment. Those assessments can vary, they can go up and down during the six-month period, sometimes by as much as 30 percent. And we think that the fair and equitable way to make this adjustment for all nursing homes

is to look at all the assessments during the six-month measurement period.

SENATOR RIVERA: Okay. So we'll certainly have many more conversations about this because I sincerely doubt that a $250 million cut to an industry that is already -- that provides services to the most vulnerable is going to help it to be better. It just -- it doesn't make sense to me. So I certainly will have many more conversations about that.

And I know I'm going to have probably another round, so I'll get a couple more in and then we'll go to the second round.

But another thing that's important that I want to talk about, since you talked about the opioid epidemic and some of the -- and certainly there have been some ways in which the state has invested money in trying to deal with the epidemic. I'll say for the record that the Bronx is still -- out of all the counties in the state, it is still the county that has the highest ratio of overdose deaths, so it's obviously something that is

very important to my community and it is not -- and I believe it's something that impacts the entire state, not just certain communities.

So one of the things that I want to ask -- and for the record, there have been a lot of conversations about safe injection facilities. I carry the bill in the Senate; my colleague Assemblymember Rosenthal carries it in the Assembly. And the notion here is that we have an evidence-based proposal that would save lives. So I want to -- and I know that there's been discussions both in the city and the state about it, and there's been some internal discussions, some articles that have been written about it.

I just want to make sure that we get you on the record. What is the administration's position about safe injection facilities, and what could we potentially do this year?

COMMISSIONER ZUCKER: Sure. So as you mention, the opioid epidemic is a big concern and the Governor, as I mentioned in my

remarks, is committed to this. And we are working on everything from working with the emergency rooms across the state to make sure we tackle this problem and have better protocols, and also on the issues of the buprenorphine, working with -- I'm going to get to the issue of the injection facilities in a second. We are doing a tremendous amount on that.

Regarding the safe injection facilities, this is -- there have been letters back and forth between the city and me on what steps can be taken. This is a challenge. It's a legal challenge. The federal government potentially can mount a legal challenge to us if one were to move forward on this. So we have been looking at this. There was an op-ed by Rod Rosenstein from the Department of Justice about this issue. There is -- we have received letters from the special prosecutor in New York City about this issue as well.

Now, I will share that since those letters have gone back and forth between the

city and my department, I have inquired about this because in an effort to do due diligence, to find out the benefits, the advantages and disadvantages of this -- so I have called, actually, Canada because that's where they have some of these facilities, and I've spoken with my counterparts in some of the provincial governments up there as well as the cities that have been doing this, to get more information. And we need to look at this and we need to do all of the necessary understanding of the pros and cons of this.

But again, I think the big issue here is the potential legal implications.

SENATOR RIVERA: So I only have 30 seconds left in first round --

COMMISSIONER ZUCKER: Oh, I'm sorry.

SENATOR RIVERA: No, that's fine. That's why the light is there.

So I will just state -- and certainly, again, when we get into a second round, well, I guess we'll start there. But one thing I'll say for the record now is that while I recognize that certainly there might be legal

issues, if we are committed to saving lives, it's something that we should actually challenge the federal government on. And I would argue that if we're going to be a state that really wants to challenge the federal government, this is the perfect area for us to do it, because ultimately it is about saving lives.

But again, I have at least three or four more things I will cover in my second round. Thank you so much, Commissioner.

Thank you, Madam Chair.

CHAIRWOMAN KRUEGER: We've been joined by Senator John Liu.

And Assembly.

CHAIRWOMAN WEINSTEIN: We've been joined by Assemblyman McDonald, Assemblyman Phil Steck, and Assemblyman Kevin Byrne.

And we go to our Health chair, Assemblyman Gottfried, for 10 minutes.

ASSEMBLYMAN GOTTFRIED: Thank you, Commissioner. Last year during the budget discussion the department agreed to create a workgroup to study the spending of Indigent

Care Pool money. It was supposed to produce a report in December. That hasn't happened. When will the report be made, and what will it say?

And related to that, there is nothing in the budget to deal with this topic. Is that because the department has concluded that the current legislation is the best of all possible arrangements?

COMMISSIONER ZUCKER: The report will be -- is getting finalized at this point, and we're working on that. I can't give you an exact date, but we wanted to take all the information from all the stakeholders who provide us information and make sure that we review this and come to a thorough analysis of the issues that were raised.

So I hope to be able to get that to you in a short period of time and don't want to jump ahead on what the report says at this point.

ASSEMBLYMAN GOTTFRIED: The re --

COMMISSIONER ZUCKER: We will finalize the report shortly. Or it is getting

finalized and we'll have it to you shortly.

ASSEMBLYMAN GOTTFRIED: And it will have an analysis of all the data?

COMMISSIONER ZUCKER: What I'm saying is that we've looked at the information from the stakeholders, and we will provide you with a report at that point.

ASSEMBLYMAN GOTTFRIED: Which is different from an analysis of the data.

COMMISSIONER ZUCKER: Right. Well, I --

ASSEMBLYMAN GOTTFRIED: Will it make any recommendations?

COMMISSIONER ZUCKER: I'm happy to share that once we get that, yes.

ASSEMBLYMAN GOTTFRIED: Okay. And the fact that the budget continues the current arrangement for another year, does that reflect a judgment by the administration that that current arrangement is the right arrangement?

COMMISSIONER ZUCKER: You know, we are looking at this in the bigger picture of the budget. And I think there are other

challenges that we have to make sure that we address when we move this forward as to where monies may come from. Some of the issues of DSH funding and whether -- you know, any changes to the ICP methods will be affected by that as well.

ASSEMBLYMAN GOTTFRIED: But in the meantime, the money is going to continue to go out the door without change.

COMMISSIONER ZUCKER: Well, let's -- I'd be happy to go through this, but I'd like to get the report to you and get it finalized.

ASSEMBLYMAN GOTTFRIED: Okay. Speaking of money going out doors, in last year's budget we provided about $20 million, I think state share, for enhanced safety net hospitals. I do not believe any of that money has gone out the door.

MEDICAID DIRECTOR FRESCATORE: I can respond, Assemblyman. That funding will be -- will go out shortly. It is funding that -- it will be distributed through managed care plan premiums, and that's

scheduled to be included in the upcoming rate change.

ASSEMBLYMAN GOTTFRIED: And why didn't that happen six or eight months ago?

MEDICAID DIRECTOR FRESCATORE: I think it was a matter of finalizing the distribution based on the statutory language for the different and various pools, and making sure certain that the distribution will be consistent with that intent.

ASSEMBLYMAN GOTTFRIED: And it has taken all this time, and I guess it's still not done, to figure that out?

MEDICAID DIRECTOR FRESCATORE: I fully expect it will be in an upcoming rate change.

ASSEMBLYMAN GOTTFRIED: Which comes out when?

MEDICAID DIRECTOR FRESCATORE: The next scheduled change for the managed-care raise would be on April 1st. So we work generally on an April through March time frame for premium rates.

ASSEMBLYMAN GOTTFRIED: Okay. The budget zeroes out funding for the Public

Health Improvement Program, and programs have been told that even though they all just signed contracts for another year of program funding, that the funding will end in two months on April 1st.

Why is the Executive proposing to terminate that funding, and why are groups not going to be able to spend the money that they have already been contracted for?

COMMISSIONER ZUCKER: Well, the program -- we are seeing the fruits of the work that that program has had through other areas, whether it's SHIP, whether it's DSRIP. And so we have had -- we recognize that none of this is really in isolation and, you know, the --

ASSEMBLYMAN GOTTFRIED: Excuse me. The programs that are out there are wasting the taxpayers' money?

COMMISSIONER ZUCKER: No, I'm not saying that.

ASSEMBLYMAN GOTTFRIED: They're doing something that somebody else is doing?

COMMISSIONER ZUCKER: No, I'm just

saying that they've done important work, the program. The efforts of the prevention agenda, the efforts of the DSRIP, the efforts of SHIP have all contributed to meeting the goals of this program as well.

And so I -- all I'm saying is that the -- it is the final-year funding, but a lot of the work that is being -- a lot of the challenges that we've met with this have been achieved through some of the other programs that we have out there.

ASSEMBLYMAN GOTTFRIED: Who is going to do the work that these programs have been doing? And have these other people been told that they are now, with flat funding, supposed to pick up the work of the Public Health Improvement Program people?

COMMISSIONER ZUCKER: Well, the -- it's not that. It's that there are -- if you look at some of the work that has been done through DSRIP and through SHIP and other areas, a lot of the objectives that were put forth in the Population Health Improvement Program have actually -- are getting achieved

there. And this was a five-year contract.

ASSEMBLYMAN GOTTFRIED: So for the last year or so they've been wasting the government's money because they're doing things that other people are doing?

COMMISSIONER ZUCKER: I'm not saying that. I'm saying that these things aren't sort of black and white, it's -- there's a transition from one area into the other.

And so we've realized the successes that we've had through DSRIP and through SHIP, and we realize that they -- this program that was in place for five years, some of the achievements were done there and we've moved over and been able to achieve them both in these other programs that we have as well.

ASSEMBLYMAN GOTTFRIED: I think it would be informative if the department, sometime in the next couple of weeks, could in writing analyze for the Legislature exactly what that means. What work that PHIP programs are doing is being done by somebody else? And how that either is duplicative

work or, if it isn't duplicative work, then how the somebody else is going to pick up that work without any increase in funding.

COMMISSIONER ZUCKER: Well, we can go through -- we can go through the specifics that -- separately or afterwards about some of the specific programs that the Population Health Improvement Program was working on and some of the things that DSRIP is doing that have now taken over from what they were doing.

ASSEMBLYMAN GOTTFRIED: Okay, that would be very useful to see written down.

COMMISSIONER ZUCKER: Okay.

ASSEMBLYMAN GOTTFRIED: The budget proposes to eliminate 25 million in funding for major academic Centers of Excellence. What's the justification for that cut? Where -- since that 25 million comes out of a pool, where will that money now go? If it's been used by these centers for some useful purpose, how will that useful purpose continue to be performed?

COMMISSIONER ZUCKER: Well, you know,

I can get back to you about the details of where some of those cuts are going to come from. We are, as we all know, in a tight budget period. I more than anyone can tell you that I value the benefits of the academic centers, having worked in them, and I recognize all that they do. And in a lot of ways we are trying to make sure that they are able to achieve the goals that they have to improving the health of those in New York. And we can give you the -- we can go down the details of what would get cut and where are the other opportunities for them to get some of those resources.

ASSEMBLYMAN GOTTFRIED: I think that would be useful to see, particularly if we can see it sometime in mid-February when we are preparing our response to the Executive Budget. Not only how many dollars go to which institutions, but what they use the money for. And if you think they're going to -- are they going to stop doing those things or are they going to get the money from somewhere else -- and if so, where?

Thank you.

CHAIRWOMAN WEINSTEIN: We've been joined by Assemblywoman Pat Fahy.

And now to the Senate.

CHAIRWOMAN KRUEGER: Thank you.

Senator Brad Hoylman.

SENATOR HOYLMAN: Yes, good morning, Commissioner. I had a question about the announcement yesterday that there's a $2.3 billion budget gap suddenly and wondered if your proposal for a 3.6 percent increase in Medicaid and healthcare transformation spending will be impacted by that. And have you been briefed by the second floor on the impact of these looming cuts and how it will impact your specific budget request?

COMMISSIONER ZUCKER: So we are always in conversation with the second floor about these issues and the specifics of where some of those cuts will come from.

Donna, do you want to touch on some of the --

MEDICAID DIRECTOR FRESCATORE: I don't know that I have anything, Senator, to add to

the announcement by the Governor and our budget director. The Medicaid funding that was included in this Executive Budget is consistent with the statute on the Medicaid global cap, which increases spending, as you know, by the 10-year rolling CPI, which is 3 percent. Plus the transformation distribution funds that I talked about earlier, that comprises the 3.6 percent increase.

SENATOR HOYLMAN: So you don't know if that announcement yesterday will impact any of this?

MEDICAID DIRECTOR FRESCATORE: I don't have any further information at this time.

SENATOR HOYLMAN: That's shocking to me that you come here today with -- I mean, that could be a massive recalibration of your budget, am I not correct? This is our last chance to really speak to you about your departmental budget, so we're left in the dark on that issue.

COMMISSIONER ZUCKER: We can get back to you about it specifically.

SENATOR HOYLMAN: Okay, thank you.

Specifically on your initiatives around e-cigarettes, I wondered if you could share your thoughts about raising the age to 21 years for purchase of cigarettes. Is there data that supports cessation around raising the age?

COMMISSIONER ZUCKER: So we have a tremendous amount of data just in general about e-cigarettes in the State of New York and those who are using them. When we've looked at this, in 2014 we had -- or actually 2015, we had about 10 percent of high school students using e-cigarettes. By the next year, it went up to 20 percent. By the next year, it went up to 30 percent. And obviously high school students, you know, on the adolescent age -- this is a remarkable increase. I have trends, and I'm happy to show you at some point the graph that we have showing this.

The other thing we've noticed as a result of the increase in e-cigarettes is for the first time since we've tracked these

numbers back in 2000, tobacco use in high school students has had an uptick. Now, it's small, but it's up. And we've never seen that before.

We feel this is attributable to the e-cigarette use. I think that if we push this age up, that it would be much, much better in decreasing use among adolescents. And the department has always been committed to preventing the use of any smoking products.

SENATOR HOYLMAN: Thank you for your work on that.

And then finally, I wanted -- if you could speak about the major measles outbreak that began in the fall -- as you say, the largest since the 1980s -- in Rockland and Orange counties. What do you think as a physician and a new father, should we be concerned about in connection with these types of outbreaks?

COMMISSIONER ZUCKER: So I am very concerned about this issue, because it goes to a bigger question of why people are not

vaccinating their children.

Now, let me give you a little bit of background. In New York State we have a 95 to 96 percent vaccination rate, which is excellent. And we lead the nation, at the top among states for vaccination. However, there are areas and there are pockets within the state where the vaccination rates are as low as 60 percent in some of the schools or daycare centers, 80 percent. And when you start dropping the vaccination rate in a community down, you lose what's called herd immunity and you really run the risk of the spread of disease.

This is a problem that has started -- has really popped up. It's not something which is just New York; it's across the country, it's across the world. In fact, the measles outbreak that we have now started as a result of several travelers to Israel who came back, after the holidays in September, to an area in Rockland County which is a community -- an Orthodox community where they were -- the vaccination rate was much lower.

Those who were in Israel actually had come -- had contracted it from those in the Ukraine, where there have been 9,000 cases since the beginning of this calendar year, 2019.

This is an issue which I recognize that we need to tackle, and we are making all efforts to do this. The number of cases has come down in Rockland County because of an incredible effort. We vaccinated 15,000 children up there. We have had 6,000 children in -- not in school or daycare as a result of making sure that we get these kids vaccinated.

And I'll add one last thing -- I know your time is up -- is that the MMR vaccine gives you a 95 percent vaccination rate at one dose, 98 percent at two doses. And it is actually New York State, back when we had an outbreak in 1989 to 1991, when there were about 6,000 cases of measles, primarily in the city, and it was my predecessor, Dr. Axelrod, who said we're going to give two MMR vaccines. Because up until that point, there was only one MMR vaccine. So New York

led at that time, and that's why the rest of the country has followed. And that's why kids get two MMRs at this point.

CHAIRWOMAN KRUEGER: Thank you, Dr. Zucker.

SENATOR HOYLMAN: Thank you.

Thank you, Madam Chair.

CHAIRWOMAN KRUEGER: Time's up.

Assembly.

CHAIRWOMAN WEINSTEIN: Assemblyman Cahill.

ASSEMBLYMAN CAHILL: Thank you, Madam Chair.

Dr. Zucker, it's good to see you. Director, it's good to see you too.

I have just a couple of questions. I'll try to make them as quick as possible.

Doctor, did you participate in the review that was being done by the federal government of the merger of CVS and Aetna?

COMMISSIONER ZUCKER: No, I did not.

ASSEMBLYMAN CAHILL: Did you submit comments or advice?

COMMISSIONER ZUCKER: I personally

didn't. I'd have to check as to whether we did, but nothing came across my desk.

ASSEMBLYMAN CAHILL: I asked that because you expressed concern about the transparency that exists for PBMs today. And it appears that that problem will be made somewhat more complex after the merger is complete and Caremark, which will be owned by one insurance company and one pharmacy provider, will be providing those services for other plans as well.

So if you didn't participate in the federal review, what exactly do you think is necessary for the regulation of PBMs going forward? And why wasn't that important enough to bring to the federal government's attention when they were considering that, and also the Cigna-Express Scripts merger?

COMMISSIONER ZUCKER: So the issue with the PBMs, we are trying to make sure that we provide a fair amount of compensation in that. And there's administrative costs and there's also -- the amount of money that Medicaid puts out for pharmaceuticals for

patients is not an excessive amount. We feel that this is a better way of moving this forward.

We've looked at this issue, and we feel that it would require a way to streamline this a little bit by having administrative costs, as I mentioned, and reimbursement rate.

Donna, do you want to add on to that?

MEDICAID DIRECTOR FRESCATORE: Yes, thank you.

As you know, Assemblyman, colleagues at the Department of Financial Services have -- may better be able to speak to it included in this year's Article VII language requirements for pharmacy benefit managers to first register and then be licensed.

The companion piece, as I think of it, in the Medicaid budget is about transparent pricing and ensuring that the state Medicaid program, the insurers in the state Medicaid program are charged an amount for prescription drugs that is equal to what the pharmacy is being paid plus reasonable

dispensing -- professional dispensing fees, of course, to the pharmacy who serves our customers, and a reasonable administrative fee.

So the proposal in Medicaid, it's about transparency, it's about making certain that there aren't pockets of surplus or profit for pharmacy benefit managers that are not clear to any of us. I can tell you I've looked at some of this data, and for one generic drug that's fairly frequently prescribed in our Medicaid managed-care program. The amount that is charged to the program for that drug by a pharmacy benefit manager ranges from about $19 to about 60 cents. We need to understand that the spend -- the pharmacy spend in Medicaid, as you know, is over $8 billion before rebates. Rebates are about 4 billion right now.

ASSEMBLYMAN CAHILL: It just continues to baffle me why that wasn't important enough to register in with the federal government when they were considering whether to allow this behemoth to occur.

I want to pivot to ACA conformity. What exactly do you think is appropriate that the state take up in ACA conformity, and what is lacking right now in enshrining into state law key provisions of the Affordable Care Act?

COMMISSIONER ZUCKER: Well, a couple of things about the Affordable Care Act and in general about our coverage. We have had an unprecedented amount of coverage in the state between our New York State of Health, our Medicaid, and we're seeing that over 95 percent of individuals are insured, which is excellent.

I think that the -- this is a commitment on the part of the Governor to make sure that we do everything we can to make sure everyone in the state has insurance coverage.

Did you want to go through the details?

MEDICAID DIRECTOR FRESCATORE: Yes.

ASSEMBLYMAN CAHILL: If you could just do it very quickly, because even though my

clock says I have 5:45, I have 45.

MEDICAID DIRECTOR FRESCATORE: I mean certainly, you know, Assemblyman, that New York had among the strongest consumer protections in the nation, if not the strongest, prior to the Affordable Care Act. Again, our colleagues at the Department of Financial Services can speak to the Article VII language that codifies the ACA. But there were certain things -- like the Essential Health Benefit selection process for individual and small group, as well as the metal tiers, you know -- that were not in state law.

The second part of the legislation, which we think is absolutely critical in the event the ACA is struck down, is codifying the New York State of Health insurance marketplace to make certain that consumers can continue to have a place to shop for and get unbiased information and any financial assistance they're entitled to.

ASSEMBLYMAN CAHILL: My time is up, but I will wait to the next round to ask you

a question, give you a chance to think about it, with regard to the proposed Gottfried Commission, the single-payer commission that you're proposing, that's being proposed in the budget, and ask for your general and more specific thoughts on that when we get back around again.

Thank you.

CHAIRWOMAN KRUEGER: Thank you.

CHAIRWOMAN WEINSTEIN: We've been joined by Assemblyman Ortiz and Assemblyman Crouch.

Thank you. Senate?

And Assemblywoman Rodneyse Bichotte.

SENATOR KRUEGER: Senator Gallivan, the new ranking member of the Health Committee.

SENATOR GALLIVAN: Thank you, Madam Chair.

Good morning, Commissioner. We spoke briefly about the Medicaid global cap. I'd like to chat about that just for a few moments. So we know that the overall Department of Health state Medicaid spending

exceeds the global cap, but there's exclusions that are taken out of it. So of course we fit everything else underneath it.

But for the seventh year in a row, the Executive has proposed using global cap funds to pay for non-Department of Health Medicaid expenses. That's over $2 billion over the last seven years. But this year specifically there's $425 million of non-DOH expenses that are under the global cap from OPWDD and OMH. Do you know what they are? Are you able to break them down?

MEDICAID DIRECTOR FRESCATORE: We can certainly get you a breakdown of those. There are expenditures that are incurred by other agencies relevant to Medicaid patients and care rendered to those patients. But I'm happy to get you more detail on that.

SENATOR GALLIVAN: Does this have any impact on the federal matching dollars for Medicaid?

MEDICAID DIRECTOR FRESCATORE: There's rules around when federal match is available. And we would need through either the State

Plan Amendment process with the federal government, or through a waiver, to be able to secure federal match for anything that we receive federal money for.

SENATOR GALLIVAN: So over the past seven years, and including in this year's proposed budget, has the using the dollars for non-DOH Medicaid expenses, has that hurt us at all, where we've been denied federal matching funds?

MEDICAID DIRECTOR FRESCATORE: Not to my knowledge. I can't think of an instance where federal dollars have been denied because of this. But we can certainly look at that too and get you that information.

SENATOR GALLIVAN: Okay. So last question with the global cap. So we have it. We talk about it. We talk about staying under it. But we have all these exclusions, so we really spend more. And we approve it every year. But we have this global cap. Is this notion -- I mean, should we just do away with the notion of a global cap and redo this and call it something else and make sure that

everything that's Medicaid related fits underneath one area so we can get our arms around it?

COMMISSIONER ZUCKER: Well, I think that, you know, the issue of the global cap just in general, we're trying to make sure we cover all these services. I understand what your concern is, but I think that we are trying to work in the best way possible to get all the necessary programs covered that we feel we can provide support for.

So I understand your question as to whether the carve-outs, you know, are moving some of the money from one spot to another.

SENATOR GALLIVAN: Because I'm new in this role, I'm trying get my arms around all of this, and -- so initially I think global cap, all right, makes sense, it's nice and neat. Well, as I'm learning, it's not nice and neat. We've got some here, some comes from here. And when you think of all the citizens of the state trying to understand it and where their tax dollars are going -- that's why I asked.

Let me move --

MEDICAID DIRECTOR FRESCATORE: If I could, I --

SENATOR GALLIVAN: Yes, go right ahead.

MEDICAID DIRECTOR FRESCATORE: But I can tell you I've had the privilege of being the state Medicaid director both in a time when there wasn't a global spending cap and now that there is, and it has clearly introduced, in my view, a level of fiscal responsibility and attention to overall Medicaid spending that I think is the rationale for maintaining this type of arrangement. And we will get you that information.

SENATOR GALLIVAN: All right, thanks.

So regarding the PBMs, we've had a little bit of discussion about it. And you talked about some of the motivation for these proposed changes. The question I have is, overall, how much does the state get currently in rebates from the Medicaid program?

MEDICAID DIRECTOR FRESCATORE: So the total pharmacy spending in Medicaid is $8.1 billion annually. That includes -- those are numbers that include the non-federal dollars and federal dollars. Most of it in the Medicaid managed care program, because of the number of people who have been moved to managed care.

The rebates associated with that are about $4 billion a year, bringing the net spending down to about 4.1 billion or so.

SENATOR GALLIVAN: Okay, thanks. Too close to the time limit to ask another one. I'll be back, though. Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Assembly?

CHAIRWOMAN WEINSTEIN: Assemblyman Raia.

ASSEMBLYMAN RAIA: Thank you.

Commissioner, good to see you. Thank you for our conversation on Friday. That will cut down some of what I want to talk about. But I just want to kind of give an overview and then let you comment after the

fact. But this round of questioning I want to talk about vaping and flavored vaping and the taxation of it.

As we discussed on Friday, I as well as many people that I know and many people across the state have successfully used vaping products as a smoking cessation device. As somebody -- you know, I'm very concerned when we talk about banning flavors. Because anyone who is trying to quit smoking, the last thing they want to smoke -- or, excuse me, consume is a tobacco-flavored vaping product. So quite honestly, those flavors are very important in getting people off of cigarettes.

We all know that cigarette smoking is bad for you, unquestionably worse than vaping. Some say the tax rate is too high on selling cigarettes. Certainly an ad valorem tax that we're proposing on vape products doesn't make sense, but that's a discussion for another committee.

But shouldn't our tax structure encourage individuals who may be current

smokers to move towards potentially less risky products like e-cigarettes? As we discussed last week, the New England Medical Journal unveiled a groundbreaking study that said e-cigarettes were more effective for smoking cessation that nicotine replacement therapy. I can personally attest to that.

Everyone is concerned about increases in teen vaping. But banning a legal product in the end is just like making possession of alcohol, selling of alcohol to teenagers -- they're still going to get their hands on it. You've got peppermint schnapps, you've got Mike's Hard Lemonade. These are all things that someone can actually -- a teenager can go pick up and hold in a store.

So if the goal is to get teenagers to stop and not start vaping, raising the age to 21 is a good place to start. You're going to take away that draw for the teenagers.

License all retailers selling vape products. Better control fake IDs with ID scanners. Age verification software for online sales. Stricter fines and penalties

for those that sell to minors. Perhaps a year in jail -- I'm pretty sure nobody's going to sell a vape product to a minor if they're going to spend a year in jail.

Make possession by minors illegal. Perhaps they lose their driver's license till they're 18 or until they're 21. As we discussed, in many instances parents buy vape products and give them to their kids. Why don't we make that covered under social host laws where we make it illegal for parents to give kids alcohol? Why shouldn't we make it illegal for parents to give kids a vape product?

All of these can be done to limit exposure to teenagers and at the same time allow people like myself that use this as a legitimate smoking cessation device to kick the habit.

But one of my biggest concerns is, quite honestly, social justice. That's an issue that seems to be the phrase of this legislative session, even within the Governor's proposed budget. I'm concerned

that if you ban flavors and potentially make possession illegal, you are going to give a police officer basically the right to search somebody's car if they smell any vape product. Because menthol smells a whole lot like mint. And if you're going to allow just tobacco or menthol, that's going to be grounds or probable cause for a police officer to search a car. And now we're going right back to the same argument that we had with marijuana, and that is a whole other discussion as far as a draw to teenagers.

On that, as you can tell, I feel pretty passionate about it. I stand willing to actually sit with you to work this out.

COMMISSIONER ZUCKER: I thank you, and I appreciate the conversation we had last week. And I actually thought a lot about some of the things that you -- all the things that you raised and some of the possible ways to address this.

And I recognize and also compliment you for getting off cigarettes. Well done.

And I would like to sit down and talk

to you about all of these issues. I mean, I've looked at some of the numbers. I looked at, as I mentioned before to Senator Hoylman about what we're seeing in high schools. We do have some of these flavors -- unicorn puke and these flavors which are clearly targeted to children. And we looked also at the numbers of people who use e-cigarettes and whether they're off -- they may be off tobacco, but the other issues that we have seen is still nicotine that they're still on, 80 percent is still a -- nicotine with e-cigarettes, versus only 9 percent through patches. But we should sit down and talk about this and go through it. I really appreciate that.

ASSEMBLYMAN RAIA: I would like that, thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

Senate?

SENATOR KRUEGER: Thank you.

Senator Diane Savino.

SENATOR SAVINO: Thank you, Senator Krueger.

Good afternoon -- it's still morning. Good morning, Commissioner. So I'm going to follow up on the discussion about e-cigarettes and tobacco use in general. I was very happy to see that the Governor included my statewide Tobacco 21 bill in the Governor's budget. That's where all good ideas go for me, apparently, is into the budget.

I've been pushing for this for a few years now, where I think most of the state now, the largest counties have an age 21.

But what we are seeing, unfortunately, is young people are using vaporizing products. And for those of you who have kids and you don't realize it -- these things, they look like flash drives, JUULs. And the problem we're seeing is that because they don't look like cigarettes, because many individuals don't realize what they are, they're overlooking their use.

We're seeing a large number of retailers, particularly the bodegas, the 7-Elevens, they are blatantly violating the

law with respect to selling them to young people. How do I know it? I have a 17-year-old nephew who started vaping JUULs a while ago. His mother and father didn't even know what they were. He and all of his friends in school are using them. And they have no problem whatsoever getting them. They walk into stores all over Staten Island, and they walk out.

And so if we're going to crack down on the use of them, which I wholly support -- although I do think there is a place in the market for people who are trying to get off of combustible tobacco. But we have to do something about enforcement, because people are buying them openly, with impunity, nobody even questions it. And we're getting young people hooked on nicotine.

And as a former smoker, I know this. It's only a matter of time before they go from the vaping product to the regular product. Especially since we're adding it to the Smoke-Free Indoor Air Act requiring people who use vaporizing nicotine to go out

in the street and stand alongside people who are smoking cigarettes. It's only a matter of time before you say "Can I have one of those?"

So yes, we need to raise the age. Yes, we need to do something about it. But more importantly, we need to find a way to get -- I'm not sure who it is that actually oversees the enforcement of the sale of tobacco products -- but to really aggressively go after retailers who are blatantly violating the law. And not giving them a warning -- taking away their license to sell lottery tickets and beer and tobacco on the first instance. That's the only way to get them to change their behavior.

COMMISSIONER ZUCKER: Thank you. I agree. Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Assembly.

CHAIRWOMAN WEINSTEIN: Assemblywoman Solages.

ASSEMBLYWOMAN SOLAGES: Good morning.

COMMISSIONER ZUCKER: Good morning.

ASSEMBLYWOMAN SOLAGES: I thank you so much regarding just the time and effort that your team has made. I did send a letter with the concern about the measles and, you know, we had a thorough discussion the other day regarding the outreach that you're doing in the communities. And so I appreciate that. Thank you so much.

I have a couple of questions, so I might go again. But the first question that I have is that the Governor's proposal -- investment of his -- his lead proposal includes in the state aid for General Public Health Work. Does it -- does there -- it seems like the proposal puts an unfunded mandate on municipal tax bases. In particular, it's cutting Article 6 funding for New York City.

Given that funding, is any of that funding going to go to other health -- departments of health throughout the state, particularly like in the suburbs or in the rural communities?

COMMISSIONER ZUCKER: So on the

numbers there, 63 percent was going to New York City, where they have 41 percent of the population. And we felt that the city -- the city also has an opportunity to get funding elsewhere from HHS, whether it's through their CDC department or other parts of the federal government.

I think when you mentioned the issue about measles at the beginning, I think that's a great example. Because Rockland County has done a tremendous job, and Dr. Ruppert, the commissioner. And the county there and our department have been working hard on this. And fortunately, she has a team that can move forward.

But if there were a problem of this nature in some of the counties where the resources aren't there, those counties wouldn't have the opportunity to turn to CDC for funding, and so they turn to the state. And they turn to us, and we want to be sure we can provide those resources to them. And that's why there was the change.

ASSEMBLYWOMAN SOLAGES: Okay. With

the lead proposal, how many additional children would require a public health intervention if the actual blood level is lowered to 5 micrograms per deciliter?

COMMISSIONER ZUCKER: So we are moving for -- I can get you the exact numbers on how many children that will be. I don't have it right in front of me. But we have worked very hard on prevention. That's the primary issue when it comes to lead.

And we also are going to work with all the physicians and health professionals besides just physicians on making sure that pediatric patients are taken care of. And we'll decrease the level to 5, and I can get you the exact numbers of how many people there are.

ASSEMBLYWOMAN SOLAGES: Do you have the figures on how much housing stock in the state is residential rental dwellings, or how many of the properties may have been built prior to 1978?

COMMISSIONER ZUCKER: Well, we can get you the numbers of how many were built before

1978, but obviously that was when the risks of lead was much higher. And we have seen this, we have seen this all -- you know, there's parts of the state -- it's an old state, and there are areas that we need to tackle.

We're also looking at this about those who rent to -- they have a house upstate and they rent out to, you know, four or five different people. And so, you know, we're looking at that issue as well. And moving forward to make sure those individuals do the right thing.

ASSEMBLYWOMAN SOLAGES: So are there any plans to provide resources to assist owners with the cost of remediation or that the cost is not passed on to the tenants?

COMMISSIONER ZUCKER: So again, I -- we can get you exactly how.

We added $10 million to the budget on lead, for lead, so we can provide resources to -- across the state for that, whether it's directly to the counties or to others. I understand your concern about the actual

individual landlords involved.

ASSEMBLYWOMAN SOLAGES: Okay. And you mentioned the savings before that could be given to other local health departments. You know, how is that going to look like?

COMMISSIONER ZUCKER: The monies that will go to the counties, you're saying?

ASSEMBLYWOMAN SOLAGES: Yeah. Like what programs are you able to provide, or what are you going to do to support the local departments of health? Because they would like to do more programs, but they find that they don't have the funding, you know, a lot of funding for that.

COMMISSIONER ZUCKER: Right. So this is where we work closely with the county health commissioners about what their needs are. And each area is a little bit different, whether it's the western part of New York, Southern Tier, North Country or down -- even here in Central New York or down in the city on this.

So there are different areas -- for example, going back to your comment about

lead, so we're the first state in the country to actually look at the water in the schools, to tackle the lead issue there. So if a community said that they need some more support on that in the county, we would be able to provide towards that. We've spent $30 million on that already, but we would keep moving on that.

ASSEMBLYWOMAN SOLAGES: Okay. I'll come back. But thank you so much.

CHAIRWOMAN KRUEGER: Thank you.

Senator Seward.

SENATOR SEWARD: Good to see you, Commissioner, and Ms. Frescatore.

I want to turn the discussion to transportation issues as they relate to your portion of the budget. And I -- first, ambulance transportation. And I would note it appears we have a number of ambulance staff workers in the audience. And as you know, Commissioner, there's -- a lot of good happens for patients in the ambulance on the way to a medical facility.

Back in 2017, the department issued

the results of their study on ambulance rates, and you issued the Medicaid ambulance rate adequacy report. And that clearly showed that our ambulance providers are substantially under-reimbursed by Medicaid. And of course we are now in the second year of a multiyear approach to make them whole, because the recommendation of your report was for a $31.4 million state share increase.

However, the Executive proposal has some reductions in what will go to our ambulance providers. The proposed elimination of the crossover Medicaid payments for Medicare Part B coinsurance, the so-called crossover -- I've seen estimates that that's a $14 million hit on our ambulance providers. And the elimination of the 3 million state share Medicaid supplemental funding, which the Legislature had put in the budget last year. So that's -- if you count the federal dollars, that's a $6 million hit.

So my question to you is, does the continued phase-in of the Medicaid ambulance

provider rate increase this year make up for the losses that our providers will be hit with due to these actions in other parts of the Executive Budget?

COMMISSIONER ZUCKER: So let me give you a little bit of an overview on some of that, and then Donna could address some of the specifics on this.

Last year in the budget we gave $10 million for EMS training issues. And we also recognized the need for recruitment and retention of EMS workers who are working hard, particularly in upstate New York, and some of the challenges there.

The exact numbers on this -- do you have the numbers on the budget? Great.

MEDICAID DIRECTOR FRESCATORE: Yes. And, Senator, I think you've summarized really the three components in the Executive Budget related to ambulance services.

The elimination of the 2015-'16 budget requirement, the $6 million that you referenced, we believe is less necessary now that we have the report and that there's a

$31 million investment in ambulance services. And the '18-'19 budget proposes to do the next installment of the recommendation of the report at $6.28 million or so. That's in addition to the current budget year, which had about $12.5 million or 12.6 million catch-up. That was actually two years of funding. So that's two of the proposals.

The third proposal related to the Part B, Medicare Part B, is really the last phase of a multi-step process that's taken place probably since the late 2000s to ensure that the Medicaid program doesn't pay more for service when a person is dually eligible for Medicare and Medicaid than it would if the person had Medicaid only.

And so that's the intent there. There's a few services -- for most services, that's already the case. There were a couple of services, including ambulance, that that change had not been made yet.

SENATOR SEWARD: Of course the concern is, as your report back in 2017 indicated, we're really over $31 million behind, and we

are still behind because of the actions in the Executive proposal, if they go through. And that's the concern, that we're still -- they're still in the hole, so to speak, financially.

Does the methodology of the Medicaid ambulance provider rate increases, is that allocated -- is there a majority of that going to upstate, downstate? Is there regional balance in the distribution of those funds?

MEDICAID DIRECTOR FRESCATORE: So my understanding of the recommendation to eliminate the supplemental payment from 2015 is that that payment was allocated -- it was about 1.5 -- the 25 percent for New York City and the remaining 75 percent for upstate. We would need to do a comparison of the investment to see -- I don't have that information with me. But we could get you that.

SENATOR SEWARD: Okay, thank you.

CHAIRWOMAN KRUEGER: Thank you.

Assembly.

CHAIRWOMAN WEINSTEIN: Assemblyman Garbarino.

ASSEMBLYMAN GARBARINO: Thank you.

I want to get back to the Medicaid drug cap. So far we -- we created it in 2017. We've now gone over the cap twice in two years.

Can you -- as a practical matter, how does the DOH pick the drugs and do the calculations? I mean, how -- I still don't understand how DOH is picking which drugs to propose go under this cap. Or to ask for additional rebates.

(Cross-talk.)

ASSEMBLYMAN GARBARINO: There's just no -- I don't -- there's no -- there's -- we put a reporter requirement in last year, now the budget is trying to take that out. I just -- you know, I don't understand how this is working as a practical matter.

COMMISSIONER ZUCKER: Well, we do have a Drug Utilization Review Board that looks at what will get approved and what won't get approved. And I know this doesn't go to part

of your question, but that will determine whether something is going to be accepted for Medicaid.

Do you want to --

MEDICAID DIRECTOR FRESCATORE: Certainly. I mean, I can outline it generally and we can follow up with you on more of the specifics, if that's helpful.

ASSEMBLYMAN GARBARINO: Okay.

MEDICAID DIRECTOR FRESCATORE: So the way the process currently works consistent with the statute is that there's confirmation or an identification that the spending -- the drug spending cap, which is laid out in statute, has been pierced, I guess, is what we call it. That is looked at as well by the budget director.

And then there's criteria for identifying drugs that are in part contributing to the piercing of the cap. There's a few different criteria. Some are escalation in price of the drug itself, and some related to sort of the frequency of prescribing, so the aggregate amount of the

drug's cost to the Medicaid program as well.

This year's budget, this fiscal year's Executive Budget includes some changes that we believe are necessary, now that we have some experience with the drug cap. It would accelerate the process for collecting rebates. And as you might know, in '17-'18 the revenue from the drug cap was $60 million in rebates; about another $115 million in accelerated collections.

So the modifications that we're proposing to streamline the process would allow the department to begin negotiations with the manufacturer before the drug was taken to the Drug Utilization Board when there's independent information about the cost-effectiveness of the drug.

It would also eliminate a couple of prohibitions in the current statute that we see as barriers to being able to work to achieve savings. One is that currently if a manufacturer's drug has -- we have a rebate agreement, we the department, we're not able to look at its cost-effectiveness. We think

that that rebate agreement should not have to expire before we begin discussions with the manufacturer.

And then the third component that we're seeking to modify the statute on doesn't allow -- or it allows for a drug manufacturer to have credits against the high-cost drug that's been identified if they're giving us rebates on other drug products. So it offsets any ability to collect.

ASSEMBLYMAN GARBARINO: Before you start having negotiations for additional rebates, I understand last year the Comptroller found $425 million in uncollected rebates that were already negotiated. Is there a process put in place now to make sure that those rebates are collected prior to asking for additional rebates?

I mean, look, it looks like there was $425 million of uncollected rebates. So, you know, that money was out there just hanging out there, and now we went and asked for more money from all these manufacturers.

MEDICAID DIRECTOR FRESCATORE: So the short answer is yes. I mean, earlier we talked about the $4 billion in rebates that the Medicaid program currently collects. And we have made some changes both internally and with our contractor to ensure that all rebates that are available are reasonably collected.

But we believe these additional changes specific to the drug cap will improve our ability to negotiate savings for the Medicaid program.

ASSEMBLYMAN GARBARINO: And you mentioned also DURB has the review and everything. But there's a proposal to remove the reporting requirements to DURB from the DOH. So how is that going to help them, you know, review if there's no reporting?

MEDICAID DIRECTOR FRESCATORE: The proposal is to do an annual report. It's to align the report with the state fiscal year.

ASSEMBLYMAN GARBARINO: So no more quarterly reports, just one annual report.

MEDICAID DIRECTOR FRESCATORE: That

was -- that is the intent of the change. It doesn't change the way we would work throughout the year with the Drug Utilization Review Board.

ASSEMBLYMAN GARBARINO: Have there been any reports yet to DURB by DOH?

MEDICAID DIRECTOR FRESCATORE: I would have to follow up and check on those reports.

ASSEMBLYMAN GARBARINO: I believe there hasn't. But all right, I'll come back and ask some more.

Thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

We go to Senator Serino.

SENATOR SERINO: Good morning, Commissioner and Director. Thank you so much for being here and for all the important work that you do for us.

And, Commissioner, as you know, we've spoken many times about this, but New York and the Hudson Valley, where I'm from, have been especially hard-hit by Lyme and tick-borne diseases, and yet every year the Senate has to fight tooth and nail to have

funding included in the budget to address this epidemic.

Since taking office, the Senate has added $2.6 million to the budget to address this issue. In last year's budget alone, we were able to secure a million dollars. But we were encouraged last year when the Governor signaled that he understood the depth of the problem by kicking off a Statewide Action Plan on Lyme and Tick-Borne Diseases. However, once again, I was incredibly disappointed to see that there was no real money included in the Governor's Executive proposal for Lyme this year.

So my questions are can you explain that? And how can we fund the Action Plan without any money?

COMMISSIONER ZUCKER: Well, we have been doing a tremendous job on the issues of tick-borne diseases, and in the course of the past year actually we -- working with -- we've developed some public-private partnerships. We're working with Regeneron for 48 -- I think it was $48 million over

five years. Well, let me just check those numbers. Yeah, $48 million over five years, for research on tackling some of the issues of Lyme disease in general.

We have worked with DEC to make sure that we get the necessary -- actually, with Parks and Recreation to get the necessary posters out there into the community to make sure that we can get more public awareness on this.

We have looked at -- we've screened, actually, over 100,000, I think, ticks, the Wadsworth Lab has, over the course of probably 15 years or so now. So we are working on this issue. And I recognize that, you know, there's always resources that help this, but it's not -- these things aren't in a silo where if there's not money specifically for ticks, you know, or for Lyme disease, it's not that it's being picked up somewhere else.

And that's where even this partnership with Regeneron and other partnerships that we have provide some of those resources.

SENATOR SERINO: And as you know, one of the issues we hear about most from patients and advocates concerns how incredibly unreliable the test is, and the devastating effects that have resulted from the lack of diagnosis or misdiagnosis, like in my brother's situation.

On May 15th of last year, the Governor announced that he was directing your department to pursue private research partnerships to develop a better diagnostic test which can ultimately lead to more effective treatments. Can you provide an update on this critical initiative, or let us know when we can expect a public update on this front? And is that part of the Wadsworth -- is that what they're doing?

COMMISSIONER ZUCKER: That's part of Wadsworth, yes. And so we will provide you with an update once we have more information. But when we did the launch and I had an opportunity to speak to some of the researchers there, I think they will make great headway on this issue. And I hope

there's a day when we turn around and say this is not one of those concerns that we have to address anymore. So --

SENATOR SERINO: Oh, absolutely. A test is such a big issue with everybody.

COMMISSIONER ZUCKER: Oh, I know. And I pulled a little tick, you know, off me and I wondered if this is a tick or not -- and it ended up not being a tick, but I sat there saying, what is this? Yeah, I know the feeling.

SENATOR SERINO: And then the last question is last year we saw the discovery of the Asian long-horned tick for the first time here in New York. And as you know, that discovery comes with so many unknowns. We know the tick poses a threat to livestock, but my understanding is that there isn't clear knowledge regarding its potential impact on humans or our environment, especially in the Hudson Valley where the tick was found.

And so I was wondering if you can provide any kind of an update on that.

COMMISSIONER ZUCKER: I'll get back to you on that. I recognize that we have seen some increase in different ticks and the concerns of whether it's ehrlichiosis or babesiosis or Powassan, and we are trying to tackle all these things. So I will get to you the specifics on some of those numbers that you're looking for.

SENATOR SERINO: Thank you, Commissioner. I just want to -- you know, my last comment is that we can't afford to take steps back on this issue at all as the number of impacted New Yorkers continues to climb.

You've always been such an important partner on this front, and I hope that you will join me in advocating for critical funding that I believe should be in the budget for places like the Cary Institute -- I mean, different places that are doing so much great work -- and we can work all together. That's what it's going to take.

So thank you very much.

COMMISSIONER ZUCKER: Will do. Thanks.

CHAIRWOMAN WEINSTEIN: Thank you.

We go to Assemblywoman Byrnes.

ASSEMBLYWOMAN BYRNES: Thank you very much.

Dr. Zucker, it's a pleasure to be able, as a new Assemblywoman, to have this dialogue with you at this hearing. So I thank you both very much for being here.

I have two questions for you, sir. In the news, at least two MLTC plans have closed in recent months. And I've also read that a very large home care provider in New York City is announcing layoffs, and they're citing as the reason the Medicaid rates. Obviously that's of great concern not only to New York City but everybody else in the entire state.

What is the state doing, sir, to assure patients that they're not going to lose their access to care and services? Basically what's being done to avoid this kind of volatility in the future?

COMMISSIONER ZUCKER: So the issue of nursing homes and long-term care in general

is something that the department is extremely committed to and, in essence, not something which there's simple answer to. It is a multifactorial problem that we have to tackle.

I'll get to the rates in a second, about that.

ASSEMBLYWOMAN BYRNES: Please.

COMMISSIONER ZUCKER: I just want you to understand that we are committed to trying to figure out how we make sure all the patients get the care that they do need.

The rates do vary in different parts of the state. We're working with all of the different nursing homes and the associations to try to make sure they get enough coverage on this so that they can continue to provide the care to those in their community.

On the Medicaid aspect, is there something you --

MEDICAID DIRECTOR FRESCATORE: Sure. Thank you, Dr. Zucker.

You know, I can speak to the concern about the managed long-term care plans. As

you may know, there are about 30 managed long-term care plans, not including the PACE or the integrated models, in the state -- a good number of them upstate, but a good number of them in New York City as well.

I think, Assemblywoman, that your reference is to two of the managed long-term care plans that have served New York City. In one case the plan has closed. That was a decision that they made, a business decision. And the other we are working closely with to transition their enrollment, about 5700 or so people, to another managed care plan on April 1st.

The profitability of the managed long-term care plans does vary some. The premium rates that the department pays to those plans, like all plans, are reviewed by an independent actuary under federal rules to make certain that they are actuarially sound. But we stand ready to continue to work with all the plans to ensure that they're working efficiently and that they have the care management and other models in place that our

patients need.

ASSEMBLYWOMAN BYRNES: All right. I have one other question, and that is in last year's budget, my understanding -- I wasn't here -- but that the Legislature instituted important controls for the Consumer Directed Personal Assistance program.

It seems to me that if we're looking, apparently, at overhauling that system again, that we haven't given due course to the changes and the reforms that were made last year. I just don't understand why we need to look to making new changes now when we still don't know whether last year's changes were effective. It just seems that we're undoing advances we already may have made, without having any idea where we're going in the future.

MEDICAID DIRECTOR FRESCATORE: So I'm happy to address that.

So I wasn't here either, but there were two changes in fact in this year's -- you know, in last year's Executive Budget. One related to fiscal intermediaries that do

administrative work related to the consumer-directed program, having to register with the department. And the other related to review of marketing materials used by fiscal intermediaries to market their services.

This year's budget proposal is intended to take sort of the next step in ensuring efficiencies in that program. About 70,000 people get their personal-care services through the consumer-directed program. And we are fully supportive of that program and consumer direction. But there are over --

ASSEMBLYWOMAN BYRNES: But do we --

MEDICAID DIRECTOR FRESCATORE: -- 600 organizations that have registered to be fiscal intermediaries. And two things need to happen. One is we need to have a reimbursement method for fiscal intermediaries that recognizes the administrative type of work they do, like processing payroll. And we need to ensure that the fiscal intermediaries that are

working, that there's a reasonable number of them and that they have expertise in working with the disability community.

I apologize, I was long.

CHAIRWOMAN WEINSTEIN: Thank you.

Senate.

CHAIRWOMAN KRUEGER: Thank you.

Senator Bob Antonacci.

SENATOR ANTONACCI: Thank you.

Commissioner, when I was the county comptroller I had a pretty liberal FOIL policy. If a reporter called me, I would actually respond to their FOIL over the phone if I could.

I've noted articles from the Times Union regarding Crystal Run and your department's I guess lack of response to FOILs regarding Crystal Run. I'm also told that you can't -- your department can't even respond to basic questions regarding technology.

Why are you unable -- your department -- unable to respond to FOILs regarding Crystal Run, something that seems

as basic as a search term?

COMMISSIONER ZUCKER: So let me discuss the FOIL process. And I have some numbers here. The -- I want to get them correct. In 2016 we received 16,497 FOILs. And over the time frame we closed 16,295. So that's a 98 percent rate of coverage or response.

This is our Department of Health's record access office, which has an incredibly talented team of many individuals. We get, on average, about 450 FOILs a month. The -- and this is about health issues. And many of these documents, some of them are as long as 166,000 pages. And the information in there has private information that needs -- some of it needs to be redacted. We're talking about people's health.

And I think it's really important that we do our yeoman's work to make sure that we don't release information that is information that is truly confidential.

With regards to the articles in the Times Union -- and they're -- the journalist

you're referring to asked the question we feel we've answered on multiple, multiple occasions. We simplified for him how the Department of Health could not conduct a search in the manner that he wanted; we were going to try to work with him on that.

What's important to point out is that we offered ways to assist him in narrowing that process. And I'd be happy to sit down and talk to you afterwards about that. And sometimes what we read is not exactly all the information that is out there.

SENATOR ANTONACCI: Fair enough. Fair enough.

So let me go to another topic about FOILs: Medical marijuana applications. My understanding is they are online but they're heavily, heavily redacted. In my hometown of Syracuse, New York, you know, a world-class reporter did an article about the flipping of medical marijuana licenses and the amount of gain that was made. There seems to be problems with your grading process. Are you responding to FOILs? I'm told by one -- I

guess you would call him a dissenter in a medical marijuana license that he's got a FOIL request that's been outstanding for three years.

Where is that process now? Are you going to disclose your grading?

COMMISSIONER ZUCKER: I think a lot of that information has been released. And if not, you know, I will check on that.

But again, some of the issues that are not as transparent is because there's proprietary information there, and that we're trying to protect the interests of the companies that are involved as well.

And so when we do this -- and this is why, back to the first part of your question, we really do need to sit down and look at this. And we all recognize how important the privacy of our own information is, and we would want to --

SENATOR ANTONACCI: Yeah, but I'm not talking about giving up the secret sauce or the recipe to Coke. You know, if someone gives you a price, that should not be

proprietary information. And I think your grading criteria shouldn't be non-disclosed, would be my recommendation.

COMMISSIONER ZUCKER: I think that that's -- I will find out for you exactly when that was first --

SENATOR ANTONACCI: Thank you. Thank you.

Real quick, on medical marijuana versus the potential commercialization of marijuana, do you think this is going to be kind of a taxicab medallion issue versus Uber? Is the legalization of marijuana going to hurt the existing medical facilities?

COMMISSIONER ZUCKER: So with regard to the marijuana issues, the Governor had asked the department to actually look at the benefits, the pros and the cons, of a regulated program. And the department, we pulled together all the experts within the government and also sat down and had many a conversation about this, and then gave a report back to the Governor showing that the pros outweighed the cons on this issue.

At this point in time, the chamber is going to have a -- there is a commission to work on cannabis and that they will have a hearing or appear before the legislature to discuss the details of whether it's a public health -- the public health issues as well as the public safety issues. So it's going to move towards an office of cannabis management.

SENATOR ANTONACCI: Okay. On the -- sounds like a fun department to work in, by the way.

(Laughter.)

SENATOR ANTONACCI: But the 2019 budget eliminated the annual subsidy to three SUNY hospitals. I represent -- or am in the area of a SUNY hospital. It looks like we're creating an annual shortfall of about 23 million. How do you expect SUNY to absorb this loss? And if we have to answer this offline, that's fine too.

COMMISSIONER ZUCKER: Right, we should sit down and talk about that. Because this is an issue that -- you know, of finances and

what we could do. But happy to sit down and discuss it.

SENATOR ANTONACCI: Thank you. Thank you, Commissioner.

CHAIRWOMAN WEINSTEIN: We'll go to Assemblyman Ortiz now. Thank you.

ASSEMBLYMAN ORTIZ: Thank you, Madam Chair.

Good morning, Commissioner. I have a couple of questions that have to do with the Comprehensive Care Center for Eating Disorders.

I have noticed that in 2005 New York State identified three comprehensive centers -- Rochester, Albany, as well as New York City -- which, as you know, specialize in providing comprehensive and integrated treatment for patients with eating disorders. They were each initially funded at $500,000 per year, which came to a total of $1.5 million.

Funding began to be cut drastically, to the point that today I believe the funding is about $150,000. And some of the centers

have had to close down as a result that they don't have the funding to continue to function.

My question to you is, is there anything that the department is doing in order to really make it a priority for these centers to continue to be functional? And I will explain quickly why. I do have a personal experience about this issue, although I started fighting for these centers back in 2004, 2005, as a result that a young lady came to my office that her father and family had to sell their houses because there was not any comprehensive in-house services in New York City.

And as a result of that, so we were blessed, with the Senate, to have legislation passed that allowed the three centers to be opened, number one. Number two, also to have some of the insurance to be coverage of this particular disease.

Personally, I will tell you that my granddaughter has an eating disorder as we speak. And this is very costly. This is

5,000, $10,000 per month. There's a milk machine out there making a lot on this when we as a state should be really emphasizing and trying to put this on their front in order to alleviate for those who cannot pay, because this is an issue about those who can and cannot.

So if you have the money, so you will be able to take her to the best facility. If you don't have the money -- so, you know, our Hispanic and minority community and those who cannot afford it, and those who cannot come out of the shadows, will not be able to do it.

So I'm asking you that make this a budget priority in our budget that will come from the Executive to make sure the way that we treat cancer, the way that we treat other diseases, that we will be able to have this center funded and up and running.

COMMISSIONER ZUCKER: Well, thank you. And I'd like to sit down at some point and talk to you about some of these issues about eating disorders and some of the challenges

that you are sharing with me now, because I do think that this is a big issue. It's not just a DOH, Department of Health; there's a lot of other components to this in other agencies that we also should be discussing this with.

And I'd like an opportunity to discuss this with you. I've cared for children and adolescents, primarily, with some of the eating disorders over the years, in training and afterwards. And so I recognize the cost that sometimes they incur from that. So let's sit down and discuss it.

And I'll find out what we do have in the budget for that, because it also ties a little bit to chronic disease and some of the challenges there.

ASSEMBLYMAN ORTIZ: Well, on that note, Commissioner, I would love to sit down with you. My office has been contacting your office since November to try to sit down and talk about this issue before the budget began.

So therefore, I do look forward to

meeting with you and sit down with you to see if we can really make this a very serious and a very mandated, through the Executive -- that we don't have to depend on the Assembly putting nothing and the Senate putting 120, and playing ping-pong with it. Because we're talking about saving lives. We're talking about people who have to probably go into bankruptcy in order for these families to keep their kids alive.

This is a matter of death and life. This is a very serious issue. And I hope that we can sit down as soon as possible to really take advantage of the budget process to see how much money we can put into it. And I will say this, $1.5 million is nothing in comparison.

And I have visited these centers. Before my granddaughter, I was fighting with this, not expecting that I would be sitting in this room now telling my story. And it's a different ball game when you tell your story. It's a very, very different ball game. As you stated, it's different

components of agencies -- and I agree with you -- psychology, mental health and others, social work. And I agree with you. I've been through the whole process. And today is the anniversary of her to be discovered with an eating disorder. It's one year today.

And it's a lot of money that has to come from people's pockets, whether it's about mental health, whether you have seen the psychiatric, whether it's about the psychology. And I think, you know, whatever we can do in order to also put pressure to the insurance companies, we should do it together.

Thank you for your concern.

CHAIRWOMAN WEINSTEIN: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Senator Pat Ritchie.

SENATOR RITCHIE: Commissioner, I know that you're aware of the significant healthcare challenges that we have in my district especially because of the rural nature. One of the places we've actually made progress is through the collaboration

done under the Fort Drum Regional Health Planning Organization, with PHIP funding. So I'm wondering what the cut in the budget -- how the state plans on continuing those initiatives that have really done a lot to bring the healthcare organizations together in our area.

COMMISSIONER ZUCKER: Sure. I talked a little bit about this before on the issue of some of the other programs that are out there. And I will get back to you about how the other programs that we have put into place can help offset some of the monies that you're -- one is not getting from the program as that program goes into its last year.

SENATOR RITCHIE: I'd like to just add that this is one time that what was put in place is really working for our area. So I would hope that you would consider looking at it and seeing if there's a way to let that continue.

And my second question is the healthcare professional shortage that's in my area that started with the doctors and now we

are at a critical level with regards to shortages for nurses. Is there anything in the budget to address that? Or what do you see that can be done at the state level to help that situation?

COMMISSIONER ZUCKER: So the -- I have to go back to the issue of workforce in general. And we are working on different ways to get health professionals to areas, particularly rural areas, and to get them to provide care, whether it's loan repayment programs, whether it's getting individuals who are in college or even earlier interested in healthcare and to be able to provide some of those services to them. We're also looking at some of the programs that we have in the DSRIP program to help use that as a means to increase workforce in the different areas.

I recognize this -- this is something which we speak about a lot in the department, and part of the State Health Innovation Plan is -- there's a whole team just looking at workforce on this. There are members of the

department that I've asked to just sort of figure out what are some of the more creative ways we can move this forward.

You know, at the end of the day the real issue is care. And so it's necessarily just a doctor or a nurse, it's like who else can provide the care. And we have expanded and are looking at ways to expand pharmacists and physical therapists and others to provide some of the services and the knowledge that they have, the expertise that they have, to help those patients or people in those areas.

So if there are specific areas that you find that you've seen from your colleagues and things that you think would work, please share them. Because there's nothing like those who are on the ground there who say this will or will not work. But we're trying to tackle this from all fronts on that issue. And I recognize it's really important.

SENATOR RITCHIE: We actually have had a number of discussions, and there are some

hurdles that it would be helpful if your department would take a look at. That maybe would help the situation.

COMMISSIONER ZUCKER: Okay, that would be good. That would be good, yes.

SENATOR RITCHIE: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Assembly? And there are some Assemblymembers joining us, and there are seats in that front middle row -- oh, they need that for someone else. Never mind.

CHAIRWOMAN WEINSTEIN: The seats are on the sides because we need access to that front row.

So thank you. And I'll introduce Assemblyman Abinanti and Assemblyman Eichenstein that joined us.

And we go to Assemblyman Ashby.

ASSEMBLYMAN ASHBY: Dr. Zucker, Director Frescatore, thank you for being here today.

Now, the Governor is proposing an administrative savings for adult home care by carving out transportation reimbursement.

What impact will this have on individuals who rely on consistent services? And can you guarantee that should the carve-out go forward, individuals won't see changes to these services?

MEDICAID DIRECTOR FRESCATORE: Yeah. Yeah. Thank you, Dr. Zucker.

So I think you're right, Assemblyman, the budget includes a proposal that would carve Medicaid transportation reimbursement out of the adult day healthcare rates and have transportation for those individuals managed by the transportation manager. That is in fact how most transportation is managed for Medicaid patients. There's just a couple of limited exceptions. This is one of them, and the other is enrollees in the managed long-term care.

We have seen over the years tremendous success using a transportation manager. There's one on Long Island and one for the rest of the state. They provide high-quality customer service. They provide trip monitoring to make certain that consumers are

well-served. And we think consolidation of the management of transportation across Medicaid makes sense.

ASSEMBLYMAN ASHBY: So is it your belief that the individuals won't see any changes to these services?

MEDICAID DIRECTOR FRESCATORE: We believe they won't see any diminution in the service they receive. In fact, we think there's an opportunity to use the processes that have been built to improve their -- improve services they receive.

ASSEMBLYMAN ASHBY: Thank you.

Transitioning back to long-term care, to the SNF population, what prompted the change in the bed hold policy that was made which reduces or excludes a 50 percent reimbursement for those who are not discharged from a nursing home but go to the hospital, and there's a bed hold on the nursing home but they're no longer receiving a 50 percent reimbursement?

MEDICAID DIRECTOR FRESCATORE: So you're referring, I think, to regulations

that --

ASSEMBLYMAN ASHBY: Correct.

MEDICAID DIRECTOR FRESCATORE: -- had been released --

ASSEMBLYMAN ASHBY: It's a bed-hold regulation.

MEDICAID DIRECTOR FRESCATORE: Yeah, that was reflective of a change in state law. I don't know off the top of my head the year. But, you know, the rationale there was that we are one of the few Medicaid programs that pays the entire cost of holding a bed in a nursing home when a patient is admitted to the hospital. There were some exceptions for some types of nursing home units like pediatrics, as I recall, and hospice.

COMMISSIONER ZUCKER: We can get you the exact numbers on that.

ASSEMBLYMAN ASHBY: Thank you.

CHAIRWOMAN WEINSTEIN: Senate?

CHAIRWOMAN KRUEGER: Thank you.

I think we're up to me. Morning, afternoon -- still morning. But you'll still be here in the afternoon.

Following up on consumer-directed care, I know there were a couple of questions raised, the questions I'm getting from my constituents is if you're changing the entire system and you may not have the same intermediaries, how can they be assured they're going to be able to keep the care they have now? And who will play the role that the current intermediaries are playing, including language and culturally appropriate people for them to work with?

COMMISSIONER ZUCKER: And you're referring to the fiscal intermediaries, right?

CHAIRWOMAN KRUEGER: Yes.

COMMISSIONER ZUCKER: So as Donna mentioned, there are 600 right now, groups working on this, and -- or organizations, who are doing this, and we're trying to streamline this so that it's more tailored to the actual needs of the patients who are benefiting from that.

So this -- we are going to make sure this is a seamless transition so they don't

end up where they feel they had somebody who understood what they were doing and now they don't. We actually think it will be tailored a little bit better when we move forward to the way we're going to do this.

CHAIRWOMAN KRUEGER: So how are you -- I guess we're asking how are you going to change it? You just -- in the budget you're saying what you're not going to do anymore, but you're not saying what you are going to do.

MEDICAID DIRECTOR FRESCATORE: So there's -- Senator, hi. There's two components. One was related to the reimbursement methodology. But I think your question is probably more about the second part of the proposal.

As Dr. Zucker said and I mentioned earlier, we've received over 600 applications for fiscal intermediaries. What this budget -- what the Article VII language does is seeks to create some efficiencies here in fiscal intermediary services. It specifically allows, and we fully envision,

that Independent Living Centers will -- can be fiscal intermediaries. By our current count, about 18 of those submitted applications to us for registration. I believe there's 56 in total. Application would be open to all of the Independent Living Centers.

And then there's a second component for organizations that were performing fiscal intermediary services as of a date certain that can demonstrate they've had experience working with a disabled population.

The other component is an abbreviated competitive process where other organizations that are interested in being fiscal intermediaries could submit a proposal to the department, it would be reviewed against criteria. We would very much like to include that, you know, capacity to serve members as well as some quality and performance indicators, as we do in most of our contractual arrangements now, to be certain that consumers are receiving high-quality, reliable services.

There's not a specific number in the Article VII of how many fiscal intermediaries there would be. But we see it as the group that's specifically identified and, in addition, others who raise their hand and want to be considered.

CHAIRWOMAN KRUEGER: Thank you.

Switching topics, there was quite a bit of discussion about healthcare costs and where the department is increasing rates or decreasing rates. So today the Health Affairs points -- I guess it's an issue of a magazine, Health Affairs, pointed out that hospital prices grew faster than any other cost in healthcare between 2007 and 2014 -- that hospital costs grew 42 percent in that seven-year period while physician prices only grew by 28 percent.

Can you explain why?

COMMISSIONER ZUCKER: Interesting question as to why. I will tell you that one of the things that we are doing -- and I'll get back to the -- is that the NY Connects, which is part of our all-payer database, is

providing the public, New York residents, to have an opportunity to see exactly why some of these -- what the costs are for services, whether it's surgery or any other medical procedure or any other test that's done in New York that compares from one hospital to another, so they get a little bit better understanding of what their community hospital versus another facility in their community or elsewhere is charging for an operation.

I can't answer exactly the specifics as to why one hospital -- you know, why some of these have gone up by 42 percent -- I look forward to reading that article -- and whether it's related to overhead -- you know, I can speculate on some of these issues, but it probably would require sitting down with the hospital associations and sitting down with others to try to get a better assessment of why we're seeing a 42 percent number versus 28 percent, and whether this is 42 percent everywhere or is this in certain pockets within the state. Or, since it's

Health Affairs, it may be they're talking about across the country, and whether that's the case as well.

MEDICAID DIRECTOR FRESCATORE: So I would just quickly add, and we'll certainly take a look at those -- that increase in inpatient, does it sound consistent with --

(Overtalk; microphone issue.)

MEDICAID DIRECTOR FRESCATORE: -- in the Medicaid program, but we'll certainly take a look.

I would mention that the Executive Budget, related to investment in physician fee schedules and other primary care, includes a proposal that would promote primary care and -- through funding that would be available through the reduction of preventable -- potentially preventable inpatient admissions. And so the proposal is one that would use funding from appropriately avoided hospital stays and invest in our Medicaid fee schedules for physicians and nurse practitioners, midwives, and other primary care providers.

CHAIRWOMAN KRUEGER: So I will ask you to go back and look at that report and get back to me. Because when I read it, I thought, okay, I knew we were trying to do all these things. We are trying to shift healthcare to being more primary care, decrease hospitalizations, more outpatient options, more in-office opportunities, more kinds of healthcare providers involved, all those good things.

So why does it seem like the basic pricing for the hospitals keeps growing so rapidly? You would think we should actually see some reduction in that. So what's why it seems so striking to me that yes, we all expect growth in healthcare costs every year, but such a dramatic growth in just one subsection. I'll ask the hospitals when they show up to testify also.

COMMISSIONER ZUCKER: I mean, we have seen, you know, DSRIP has -- what you mentioned before, we're trying to keep people out of the hospital, out of the emergency room, and that probably impacts on how many

people are ending up in the hospitals and -- I can speculate a lot, but it's probably for me to read the report first on this.

But I will say that we've seen a 17 percent decrease through DSRIP so far. With some of the hospitals, I should say.

CHAIRWOMAN KRUEGER: Great. And then finally, it seems perhaps a little subtopic, but some people were talking about healthcare in their communities. My community, which is what I call Bedpan Alley sometimes, and Research Alley, the -- many of the medical research groups doing stem cell research are in my district, and they continue to point out to me that even though the state appropriates approximately $45 million each year for the New York Stem Program, to facilitate continued stem cell research, we only actually distribute between 20 and 25 million every year.

Where is the rest of it going, and why can't we move that money out to the researchers who think they're going to get it and get themselves into all kinds of problems

when it doesn't show up?

COMMISSIONER ZUCKER: Well, I know the money that -- we gave the money out for some of the stem cell research last year; there was a discussion that we had whether it was here or subsequently about that. I will find out the balance of where the additional money is. You know, I'm a big supporter of the whole stem research that's out there. And you're right, you have a lot of institutions that are doing a lot of that research right in your area.

CHAIRWOMAN KRUEGER: And they report that there hasn't been a new RFA since 2016 for continued funds to be able to be distributed, so that could be part of the holdup. They can't apply for the money that's supposed to be there in the budget if you don't release RFAs.

COMMISSIONER ZUCKER: Let me find out.

CHAIRWOMAN KRUEGER: Thank you.

Assembly.

CHAIRWOMAN WEINSTEIN: Assemblyman Byrne.

ASSEMBLYMAN BYRNE: Yes, thank you, Commissioner and Director. Can you hear me? Okay, great. Thank you.

I want to thank you for your time and your testimony this morning. I know it's been a long start to the day. And I want to kind of switch back again just to talk about the Medicaid program in general in New York State. I understand that we have the second-highest price tag of any state in the nation. I think we're just behind California, totaling about $74 billion. And of course that also includes the federal portion, about 41.9 million, 24.7 billion from the state, and 7.3 from the local level.

I wanted to clarify a piece too. My understanding is in this budget proposal about a little over a billion dollars goes towards costs for the increasing of the minimum wage. I wasn't here when we did that, so I'm not trying to -- I want to just make sure that that is a point of this budget proposal as well. That's accurate?

MEDICAID DIRECTOR FRESCATORE: Yes.

ASSEMBLYMAN BYRNE: Okay. So my question would be, do you have any insights, then, as to why the number of enrollees in the Medicaid and Essential Plan are increasing, because my understanding is one of the primary arguments for when we raised the minimum wage was to help reduce poverty. And it seems that use continues to increase. And if you have insights on that, and if there's -- as to the effects of the raising of the minimum wage.

COMMISSIONER ZUCKER: The Essential Plan covers 700,000 individuals in the state, which is excellent. We had a 30,000 enrollment increase since January of last year, January 2018. The details -- do you have the numbers on the details with you?

MEDICAID DIRECTOR FRESCATORE: Certainly I can -- let me see if I can kind of take those questions a little bit one by one.

So the Essential Plan covers individuals up to 200 percent of federal poverty level. What we see when we look at

those individuals is they are in fact low-income working New Yorkers. They may not work full-time; they may work at seasonal jobs. That's an annual basis for their income.

I think the other thing noteworthy about the Essential Plan is that New York was one of two states that assumed the -- it's the Basic Health Program option in the Affordable Care Act. We branded it the Essential Plan here. And that decision brings significant federal dollars into New York -- over a billion dollars, as I recall, because we're able to get federal dollars for care for services to people who would not otherwise have been matchable under Medicaid. So I think it's important to bear in mind who's covered by those programs as well.

I missed the other part of your question, though, I think.

ASSEMBLYMAN BYRNE: My question, the root part of it was about the minimum wage increase, the billion dollars that's going

towards minimum wage. And are we making sure that these folks that we want to make sure that they're not in poverty, that -- is this -- they're still using this benefit, is my point.

So one of the things I wanted to circle back to -- I really just wanted to tee that up. I know my conference has some proposals, I'd like to hear your insights about it -- the leader of my conference, Brian Kolb, has -- I believe he introduced this bill last year, Assembly Bill 9901, and it's something that we talk about a lot. And part of this is talked about in cost, in phasing-in a takeover of the share of the local government, their costs for the Medicaid program. But in addition, the idea of eliminating the benefits cliff so we can incentivize people to get to work and possibly even come off the program.

And I just wanted to listen to see if you had any thoughts about that proposal. It's something I think we've heard members talk about. And if you can answer that. I

have one more question after that, so let's see if you have any response. You can also look at it and get back to me later.

MEDICAID DIRECTOR FRESCATORE: Yeah, so just a couple of quick comments.

First, I think this -- the proposed Executive Budget in fact assumes the additional funding from the local social services district, so in fact that is part of what is counted --

ASSEMBLYMAN BYRNE: It's the growth, though.

MEDICAID DIRECTOR FRESCATORE: It is the growth, right, consistent with legislation that was enacted several years ago.

The other thing I think I would tell you, having worked in both the commercial insurance world and in the government programs, is programs like the Essential Plan are in fact that kind of bridge for individuals who earn too much for Medicaid but don't quite earn enough to buy insurance on the individual market. And so we see a

lot of working, lower-income working New Yorkers who, based on their household income -- that's the other thing to remember, that these tests are on a household, not one individual's earnings.

And I think that is a bridge for them. It has no annual deductible, it has very low cost-sharing --

ASSEMBLYMAN BYRNE: I'm sorry to cut you off. I want to thank you. I got 10 seconds left --

MEDICAID DIRECTOR FRESCATORE: Okay.

ASSEMBLYMAN BYRNE: I want to make one quick comment, because it's been brought up before, about e-cigarettes. I supported strengthening the Clean Indoor Air Act, I supported banning it on school grounds. And if we just keep banning products without enforcing it locally, I'm not so sure that's going to solve the problem, because we've got tons of students in my schools in my district still vaping. And it's illegal.

COMMISSIONER ZUCKER: Thank you.

CHAIRWOMAN WEINSTEIN: Senate, do you

have any --

CHAIRWOMAN KRUEGER: The Senate has second-round questions, but we're going to allow the Assembly to continue their first round before we go to our second round.

CHAIRWOMAN WEINSTEIN: So Assemblyman Barclay.

ASSEMBLYMAN BARCLAY: Thank you, Chairwoman.

Still good morning to you both.

Appreciate hearing your testimony.

I have what I would consider a general question and then a very specific question on the Governor's proposal, and then I have two other questions -- I don't even know if I even understand one of the questions. So bear with me if you can.

(Laughter.)

ASSEMBLYMAN BARCLAY: I know my colleague Kevin Cahill asked about universal healthcare in New York State. Do you have a position on that, or do you support -- or do you say we have to study it more? Give me some clarification.

COMMISSIONER ZUCKER: So the Governor would like to have -- will have a universal -- a commission to study the issue of universal coverage. And I think that I'd like to see what comes out of that. I think this is the right step to move this forward, to get more information.

I am pleased, as I mentioned before, that we have 95 percent of the state covered.

There are many complex aspects to this, and I think that we need to study it and listen to the experts, whether it's in the insurance industry or elsewhere, to better understand that. And I applaud the Governor on what he wants to do.

ASSEMBLYMAN BARCLAY: All right. I look forward to a study on that also.

As far as transportation and Medicaid reimbursement for transportation, I see the Governor is proposing to cut rural transit assistance. Could you explain that to me, or why?

COMMISSIONER ZUCKER: I'm not clear on the question. Can you --

MEDICAID DIRECTOR FRESCATORE: Yes. Yes. I mean, I can address this and follow up with more information on --

COMMISSIONER ZUCKER: Oh, sorry, rural transit, yes. Sorry.

MEDICAID DIRECTOR FRESCATORE: So at some point in the past I think there was funding in the budget to assist with the transition of payment for transportation services in certain rural areas. What the budget does is it eliminates state funding that's used to currently support transportation that is not related to the Medicaid program.

ASSEMBLYMAN BARCLAY: Okay. All right. Thank you for that clarification.

Organ donation. Obviously New York has some terrible statistics on our organ donation participation. I know that DOH can collect the funds -- or gets the funds that are collected by the DMV. Do you know how much -- how many funds have been collected so far and how much has been spent?

COMMISSIONER ZUCKER: I don't know the

number on the funding, the actual number.

I do know that we have 5.5 million New Yorkers who are registered as a result of the efforts that we have made. And I know this was a challenge and we were down on the list as states go, and we've made a concerted effort to address this both by not only how we tackle this from the Department of Motor Vehicles but also New York State of Health and many other ways that we have gotten -- we've had people sign up. We've put Lauren's Law into -- we made that permanent, and many other things that we've worked on to address this.

And I'll get you the numbers.

ASSEMBLYMAN BARCLAY: I appreciate that. And anything we can continue to do to try and encourage more people to be organ donors obviously is a good thing. And we want New York not to be last in that category, we'd like it to be first in that category.

Okay, now to the question that I think I'm on the edge of understanding, I

apologize. But as we know, the Essential Plan, you're going to take cuts from the federal government because of the cost-sharing reductions that have been proposed, correct?

COMMISSIONER ZUCKER: Yes.

ASSEMBLYMAN BARCLAY: Last year you transferred the Value Based Payment quality program into the Essential Plan trust fund. And there's a question whether that is permissible to do. And if the federal government ends up auditing us at all, do we have any backup plans? Do they say you can't use that program in the Essential Plan trust fund?

MEDICAID DIRECTOR FRESCATORE: So last year's budget did include a transfer of quality programs from Medicaid in part to the Essential Plan. We will implement those quality programs in the Essential Plan, as we would any quality initiative for the 700,000 -- almost 800,000 people who get their services through the Essential Plan.

ASSEMBLYMAN BARCLAY: All right.

Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Continuing with the Assembly, Assemblymember Steck.

ASSEMBLYMAN STECK: Thank you very much, Senator.

I wanted to return to the fiscal intermediaries for a minute. I am chair of the Task Force in the Assembly on Disabilities, so this issue has been brought to my attention. And I want to say one thing personally, is that we certainly in my district understand the importance of not letting Medicaid spending get out of control.

We also -- and I think the advocates for people with disabilities certainly support strongly the idea, as I understand it, there's a certification process ongoing for these fiscal intermediaries, maybe -- there are certainly some that will be weeded out in that process, and that will create greater efficiencies, and I think everyone supports that.

What people kind of don't understand

and don't see as very rational, the idea that we're going to just artificially cut costs of fiscal intermediaries administering services on behalf of the people they are serving down to a per-member per-month payment of $100. The rationale for that, as I understand it, is that administrative costs have been growing as a percentage of the program, but that's really a self-defeating argument because you haven't increased at all the funding to the people that -- for the services to the people that are being served. Meanwhile, the costs of administration are going up. They haven't been sitting still, the economy hasn't been sitting still.

So really the only reason that it looks like the administrative costs are growing up as a percentage of the program is because everything else has stayed flat. And it seems to me and to the advocates that while we support the idea of qualifying the fiscal intermediaries, it tends to artificially limit to a very low level what they can charge for dealing with people with

very complex needs. It seems like it's just not the right way to do business.

What are your thoughts on that?

MEDICAID DIRECTOR FRESCATORE: So maybe I can clarify the rationale.

First let me say that the savings that are attributed to this proposal are in no way related to the hourly cost of providing care or the number of hours that individuals receive from the CDPAS program. We are fully committed to CDPAS, and we are fully committed to the idea of self-direction. In many ways it helps address particularly some of the issues that Senator Ritchie raised in areas of the state where there are some shortages.

ASSEMBLYMAN STECK: But that wasn't --

MEDICAID DIRECTOR FRESCATORE: What we don't --

ASSEMBLYMAN STECK: I'm sorry, but that wasn't really the point. Maybe I wasn't clear. The point was that because you've frozen, in essence, the benefit to the individuals who are being served, and the

costs of administration have been increasing, just as a natural part of economic life, it makes it look like the costs -- the percentage that's going to administration is going up when in fact that is not the case. That's the point.

MEDICAID DIRECTOR FRESCATORE: No, I'm not certain that we would respectfully agree, Assemblyman Steck. The way those services are currently paid is they are a percentage of the hourly cost of the care. They're about 15 percent, and these are for services like processing payroll and doing payroll taxes that are largely fixed costs. And in fact as the hourly rate increases for the service, including because of minimum wage adjustments, the administrative costs of the program follow suit.

We believe that the more appropriate way to reimburse for administrative, largely fixed costs is on a per-member per-month basis, and that that reimbursement should be fair and reasonable to the costs of payroll and other --

ASSEMBLYMAN STECK: Our understanding is that's what you're doing now, and you're just reducing it. They are being paid about $150 to $500 per person that they serve, and you're just arbitrarily reducing that to 100.

I think that your concept of achieving economies of scale within the program by certifying these fiscal intermediaries is a good concept. The problem is just saying we're going to cut the payment to the people for providing those services, the fiscal intermediaries. That's where we're not finding anything other than artificial cost cutting.

MEDICAID DIRECTOR FRESCATORE: Well, I'm happy to talk about it more, about the current methodology, which is based on a percentage of the hourly worker's rate.

CHAIRWOMAN KRUEGER: Thank you.

Assemblymember Crouch.

ASSEMBLYMAN CROUCH: Thank you, Commissioner, for being here.

I have got a couple of questions, actually three. In reference to the Oxford

Vets Home -- Oxford is in my district, Chenango County -- one of the four vets homes that the Department of Health runs, basically, for our veterans, we've looked at a nursing shortage there for a number of years, had communication with your office on whether or not they were able to get waivers -- this was about three years ago -- to hire new people. I kept hearing that they were not able to get waivers. I think we've gotten over that at this point in time.

To my pleasure, the vets home has conducted some job fairs and been able to hire people. However, there's still a shortage. And God bless the people that work there; they're working 16-hour shifts, sometimes, to make sure that our veterans are cared for. And I've been in the home different times and you could literally eat off the floor. I think they run a fantastic operation there.

I'm disappointed that there's still a 42-bed wing that's closed, which was closed because of lack of staff. That means there's

possibly some veterans out there that are not being served. And I'm just wondering, is there anything in this budget that would help sweeten up the salaries to be able to attract adequate nursing staff or adequate staff, period? I understand there's maybe a regional differential that's not being paid in Oxford. And if that's the truth, then why?

COMMISSIONER ZUCKER: So we work very hard to make sure that anyone who -- any veteran who has served our country well has an opportunity to get care and to get into a veterans home. And we do tailor each person to exactly where they need to be, whether it's a location or the particular services that are there.

We understand about the situation with some of the beds closed, and we have been working on that to make sure that nobody gets in any way compromised care. I'd be glad to sit down and go through a little bit more about that. I understand that there's more -- a bigger picture than just nursing,

staffing and those issues as well. So it goes to a bigger question.

But we are making sure that we provide the care and services to the veterans. If there's a specific individual that you've heard about, please let me know and I'll --

ASSEMBLYMAN CROUCH: I don't think anybody is being shorted on care. I think the staff there is wonderful. I mean, I've commended them, and I made a personal visit just to make sure the administrator knew that any comments that I made was not a derogatory comment about the care that the staff was giving.

I'm concerned that they're all being overworked, and I know personally of a lady that worked there for 10 years, she was fairly young, loved it, yet working 16-hour shifts all the time, she said, "I got burnt out." She had to go on.

The second piece, there doesn't seem to be the availability of hospice care in any of our veterans homes. And I guess that's -- I'm questioning why. The response I've

gotten back in the past is, Well, we think we do a pretty good job. That may be true. But the hospice incorporates the family in their moment of grief while their loved one is passing through.

And when you look at this denial, basically -- any veteran that's on Medicare or Medicaid, any person is entitled to hospice care. But yet there's no hospice care available. I wouldn't ever say that the staff is not doing a good job in end-of-life care, but let's go back to the shortage of nurses. Why wouldn't you want professionals that come with the hospice program in the vets home providing end-of-life care so the nurses can go on and take care of the rest of the vets?

COMMISSIONER ZUCKER: We should -- we will work on that as well. And I concur 100 percent with you that the services that hospice care provides to not only the patient but the family, primarily, on this --

ASSEMBLYMAN CROUCH: And these are people already with a background check and

the professionals. And I would urge you to look at that.

COMMISSIONER ZUCKER: Will do.

ASSEMBLYMAN CROUCH: One last thing -- and that's going back to an issue that we've discussed in the past, at least through our correspondence. But the Visitors Board, the Governor has yet to really appoint anybody, since -- or very few people since 2010. It's a statutory requirement that these people are appointed -- five men, I believe, and four women. They all have to come from a congressionally approved veterans organization like American Legion or whatever.

And in our correspondence in the past, our discussion in the past, I was encouraged to send over -- if I knew anybody that would want to serve, send over their name, which I did. I had one career, 30 years in the military, now retired, volunteers at the vets home, and he wanted to be on the Visitors Board. Another gentleman was a chaplain for two of our correctional facilities for many

years, retired from that, became a minister in a local church, now fully retired but very active in volunteering for the vets home.

Submitted his resume, submitted both of them. They were met with a thick packet of information that they had to fill out. And the one gentleman that was career military said, "I was assigned security duty to the governor at one point in time" -- not this governor, but still -- so he must have been able to pass the background check. But yet they were put off and finally they rescinded their names because of the information required as the background check.

Now, these individuals are going in and out of that home all the time as volunteers, and all they want to do is sit on the board and have a discussion with other people about the care of the vets, you know, programs for the vets, things like that. And I think it's ridiculous that you look at the individuals that were submitted, and they have to go through a complete background check -- I mean, you could get a good enough

background check on these guys by going to the local sheriff, just like you would if you were applying for a firearm permit.

And I just find it ridiculous that we're subjecting them to that kind of an intrusion, and we ought to look at that.

CHAIRWOMAN WEINSTEIN: Thank you, Assemblyman. Perhaps you could continue this conversation offline.

We're going to go to the Senate now.

CHAIRWOMAN KRUEGER: Thank you.

Senator John Liu.

SENATOR LIU: Thank you, Madam Chair.

And thank you, Commissioner, for joining us today.

I have a quick question about something that you may -- your department may or may not be aware of, and that is this I guess emerging phenomenon of maternity hotels. These are facilities where some women, mostly in immigrant communities, as far as I know, have had extended stays immediately before and for a few weeks after the delivery of their babies. Apparently

there is no regulation or oversight of any of these facilities.

I'm wondering to what extent you or your department may know about these things and if there are any plans to address that.

COMMISSIONER ZUCKER: So this came to my attention just recently, within the last couple of weeks I had heard about this. And so let me get back to you. I read a little bit about this, but I need to find out more detail before I can give you an educated answer on that. But I recognize the --

SENATOR LIU: Yes, that would be fine, Commissioner. I mean, it would be fine if you just have somebody in your office reach out to me. And there are a number of issues I want to discuss. I'm not necessarily calling for regulation, but I think there needs to be some kind of dialogue.

COMMISSIONER ZUCKER: All right. Sure.

SENATOR LIU: Thank you.

CHAIRWOMAN KRUEGER: Assembly.

CHAIRWOMAN WEINSTEIN: Thank you.

Assemblyman McDonald.

ASSEMBLYMAN McDONALD: Good morning.

COMMISSIONER ZUCKER: How are you?

ASSEMBLYMAN McDONALD: First of all, as one who represents three counties in the Capital Region, Wadsworth at Harriman Campus is a win for the region. Thank you very much.

In the overdose arena, the PMP checks in the emergency room -- which is a great idea and concept. You know, unfortunately, the emergency rooms still have a lot of frequent flyers. My concern is that it's difficult enough for physicians in primary care practice to check the PMP. Is there going to be an effort to include interoperability so that way ER physicians, primary care physicians can actually make this part of their seamless workflow?

COMMISSIONER ZUCKER: Right, we're working on that. And we've spoken about this before; I had to make this is a little bit more user-friendly. And we're working on that, and it's taking a little bit of time

before we get there.

ASSEMBLYMAN McDONALD: The Medical Society estimates maybe about a half-million dollars will bring in most of the EHR systems. It would be good, particularly as we're going through this Medicaid redesign and changing towards value-based outcomes.

PBM reform, it's long overdue. It's important that every player, from the manufacturer down to the pharmacist and the patient, actually, have transparency. Information is good. And as pointed out either in your report or Troy's report, they do serve an important purpose.

That being said, a couple of things. In the report it talks about pharmacy reimbursement, the methodology will be changed. Has that been determined yet? And I'm not really looking for the specifics of what it is, but when will it be discussed or announced?

COMMISSIONER ZUCKER: I'll find out for you.

ASSEMBLYMAN McDONALD: Okay. Because

that, I would think, might have some budgetary implications for the state and for everybody else involved.

Then along with that, tangential to that, you know, obviously every industry still needs to generate a profit to pay their bills. Are there going to be protections put in place -- now if we say we're going to change this reimbursement methodology, PBMs, you need to do it this way -- which the State of Ohio has done, I believe the State of Alabama has done, to address the spread pricing -- is there going to be protections put in to make sure that another fee doesn't just show up that's going to have a negative impact for any provider, whether it's hospital pharmacy, chain pharmacy, independent pharmacy?

COMMISSIONER ZUCKER: Well, the goal is to streamline this and to make it more user-friendly and less costly. So --

ASSEMBLYMAN McDONALD: I agree, but I'll give you good example. Every time a pharmacy transmits a claim, it's 15 cents for

a prescription to go through, whether it's accepted or rejected. And sometimes it takes 10 to 12 times to get a claim through. That fee used to be 12 cents. It went up 15 cents last year out of the blue; it could go up to $1.50 tomorrow. And, you know, what I'm looking at is when we see in other states that the average spread pricing was $6.50 a claim, it's not inconceivable to say, okay, you know what, we're going to support this effort -- oh, by the way, pharmacies, your transmission fees -- which is critical to providing care to the patient -- is going to increase.

So I think -- I just want to make sure it's on the record that it's being included in the dialogue.

And I guess the other question -- the data, the numbers are interesting; you're saying the Medicaid spread for drugs I believe is about $8 billion, and the rebates are about $4 billion. So I guess it brings up the other question, is -- because there's so much questions about, you know, who's

making what. And for all we know, maybe everyone's just playing it straight-edge.

But has the state really gone back and reconsidered maybe just carving the drug benefit back out and allowing our current fee-for-service system to exist? Has there been any further discussion in light of all these reports coming out about the lack of -- you know, the challenges with PBMs?

MEDICAID DIRECTOR FRESCATORE: I would say, Assemblyman McDonald, that that question comes up from time to time. The reason that we moved forward here in the Executive Budget with the recommendation that we did is that we believe that the managed-care plans bring some -- bring to the patient and bring to the program the ability to integrate the pharmacy benefit with the medical benefit and the behavioral health benefit.

So from our perspective, transparency for the pharmacy benefit manager -- and I hear your comment about the transmission fees, which I think we would consider part of administration. But the combination of the

plan's management of the benefit with PBM transparency could be, in effect, the best of both worlds.

ASSEMBLYMAN McDONALD: Okay, good.

The other thing, just jumping onto the whole ambulance reimbursement, you know, we've had some challenges here in the Capital Region. We have EMTs working tirelessly for like 12 bucks an hour. The whole system needs some kind of revamping. The cutting out the crossover billing is really tragic, because as a provider I know what that impact could be. And hopefully we can use some of these transformation funds to take care of our other nonunion human service workers out there.

Thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

And a while ago I forgot to mention we were joined by Assemblywoman Aileen Gunther, chair of our Mental Health Committee.

Now to Assemblywoman Bichotte for a question.

ASSEMBLYWOMAN BICHOTTE: Thank you,

Commissioner, for being here and for your hard work.

I have three questions -- I have actually a lot more questions, but for now three questions. I'll ask them first, and then you can answer.

Around the nursing home case mix methodology, I just want to say that there are some concerns. I understand that the reason why there's some reduction is potentially fraudulent activity is happening and they want to regulate. But again, the cuts -- when I look at the long-term care reductions, about 250 million, that's like a 30 percent reduction in the nursing home industry. I'm very concerned about that. You know, my mom utilizes the nursing home facilities very often, so that's something that I would like to address, I would like for you to address.

The next question is on the ambulance reimbursement issue and the eliminating of the crossover, Medicare-Medicaid. Now, for many patients like my mother, who's worked in

this country for over 30 years as a union labor person -- not much of a pension, not much Social Security. She has Medicare, Medicaid. And to think that now, you know, she won't have the 20 percent supplement that Medicaid allows her to pay for her medical expenses -- in particular, transportation -- my mother's 80 years old and she's in and out of the hospital, in and out of the nursing home rehab.

Just the other day, two weeks ago, Mom wasn't feeling well and she, you know, called 911 -- and I didn't want her to call 911 because I wanted her to have that choice to call that ambulance service that would take her to the hospital with all her doctors. She went to that hospital, she didn't like it, she got discharged, went back home, called the private ambulance service, they took her to the right hospital with her doctors. Then she went to the nursing home for rehab, wasn't feeling well, went back to the hospital and now she's back in the nursing home rehab. She's 80 years old.

COMMISSIONER ZUCKER: I know the story.

ASSEMBLYWOMAN BICHOTTE: Imagine if you take out or cut the crossover, Medicare-Medicaid. That would be very, very expensive for my mother. And just imagine the many elderly patients who are like her.

So my question to you on this issue is why are they eliminating the crossover of Medicaid and Medicare, and have you guys talked to providers and hospitals on what would the impact be? This is like a $14 million cut in the ambulance industry.

And my last question is around home care. The Legislature has provided monies to assist in paying home-care workers the increased minimum wage. But we understand that these monies are not getting to the providers because the managed-care plans don't pass it through. What is the department doing to make sure that all the money, over a billion dollars, gets to the workers?

COMMISSIONER ZUCKER: So in the

interests of time, let me see if I can answer a few of those and then Donna may answer the one on Medicaid.

With regards to the nursing homes, we are looking at making sure the quality is excellent. And so we will -- in the department's proposed legislation it includes the permitting of our department to appoint an independent quality monitor to look at some of these issues. Because even -- we don't want nursing homes that are open that are just not providing the care. So we're working on that.

And I recognize that a lot of people use them, and we're also looking in general how are we going to tackle some of these issues of those who are elderly who want to either be in nursing homes or be home. So that's a bigger issue. And it goes back to the home care issue as well that you brought up regarding monies that are being paid to those aides and how we can move that forward.

So I'm -- we as a group are going to try to answer some of those questions as we

move forward, particularly the home care, and as we tackle the aging issue.

On the Medicaid issue, Donna, do you want to answer the issue about the money --

MEDICAID DIRECTOR FRESCATORE: Yeah, maybe I can go through them. Thank you, Assemblywoman.

First on the nursing home acuity, you know, the intent here is to fairly reimburse for changes in nursing home acuity using all of the assessments available.

I might have been confusing on the numbers before. The Executive Budget savings for this proposal is about $245 million that's both the non-federal share and the federal share, as Senator Rivera pointed out earlier. That's on a $6 billion spending base. So I don't think that's -- you know, it's far, far less than 30 percent.

On your -- and I perfectly, perfectly hear your concern on the Part B crossover. My mom had the same scenarios going on. What this proposal would do is it would not eliminate the crossover payment to the

ambulance, but what it would do is limit it to how much Medicaid would pay.

There are -- and we can get some clarification for you, but there are prohibitions on providers balance-billing individuals who are Medicaid-eligible. It is very likely that your mom would not get a bill, because that would be a substantial bill. But we will get you more information on those prohibitions on balance billing patients.

And then on your question or your comment about minimum wage and home-care workers, over the past many months we have been working very closely with managed-care plans and with individual home-care providers and personal-care providers to ensure that the funding that's been made available through premiums to the managed-care plans is appropriately being passed down to providers to meet their minimum-wage obligations and what the worker's entitled to under the law.

CHAIRWOMAN WEINSTEIN: Thank you.

I have a quick follow-up to some of

what Assemblywoman Bichotte was talking about, because I too share concerns. And also Senator Seward had raised the issue of the crossover concerns. So obviously you went through some of the detail relating to the impact on the ambulances.

I've heard from physicians, from psychologists about the potential impact particularly on patients, particularly because of the new Medicaid -- federal Medicaid rules coming into effect in October, and concerns that without -- they won't be able to be doing the diagnoses in the nursing homes, which would obviously result in a lot of loss of federal dollars if that loss of that 20 percent prevents them from being able to provide affordable services.

So I guess I just want to continue with the concern and just -- if you could just talk a little bit more about how you considered the impact of the proposal on the delivery of the healthcare services, and if, how, when.

And we thought -- you just had a

number in the 200-plus-million range. We thought that there was 35 million in savings attributed to the elimination of the crossover.

MEDICAID DIRECTOR FRESCATORE: No, the 245 million was related to the nursing home acuity, which I think was the first question that the Assemblywoman asked.

CHAIRWOMAN WEINSTEIN: But the crossover --

MEDICAID DIRECTOR FRESCATORE: The crossover -- yeah, the crossover savings is a smaller dollar amount. I think you have it exactly --

CHAIRWOMAN WEINSTEIN: Right, 35 million?

MEDICAID DIRECTOR FRESCATORE: Let me -- it's 17.5 million state share in the first year, which would double to 35 million with federal matching dollars.

You know, this is, as I mentioned earlier, we have over a large number of years here, dating back to the early 2000s, made changes to align Medicaid payment for duals

with non-duals. Right? So that the amount Medicaid pays is the same whether or not the person has Medicare or only Medicaid. And what you see in this Executive proposal -- I think you summarized the types of providers exactly right -- would apply to the remaining providers, where the Medicaid program is actually paying more for service when Medicare is the primary payer than when Medicaid is the only coverage the individual has.

Based on our prior experience in making this alignment, we are not anticipating that there would be significant shifts in providers in the Medicaid program, and taken in combination with some of the other initiatives as well in the budget that invest in primary care. But we're happy to talk more about that history, it's a multiyear history I use, you know, all the time here. We're happy to talk about that.

CHAIRWOMAN WEINSTEIN: Sure. I'd like to continue as we go through negotiations on that issue.

We have one more Assemblymember for the first round before we go back to the Senate and Assembly for second rounds.

Assemblyman Abinanti.

ASSEMBLYMAN ABINANTI: Thank you for joining us today.

There's a children's game called musical chairs, and the people with disabilities are starting to feel that every year that we've had a budget -- for the last eight years that we've been playing musical chairs with all of the programs and all of the services, except instead of one chair being removed, it's two or three. And people with disabilities can't find the chair at all, and so they're getting knocked out.

So I want to express a significant concern by the disability community about all of the things you're proposing.

First of all, let me start with a general question. You stress -- I want to talk from the point of view of people with disabilities. You talk about self-direction as being the way to go. Isn't Medicaid

managed care a contradiction of that, especially since you're moving just about all of the services that people with disabilities get into Medicaid managed care?

MEDICAID DIRECTOR FRESCATORE: When I used "self-direction" in the context of the Consumer Directed Personal Assistance Program, it was intended to be that individuals, both who are on Medicaid fee for service and individuals who are in Medicaid managed care who are self-directing, who want to and are able to --

ASSEMBLYMAN ABINANTI: But what services are still going to be self-directed if everything is going to --

MEDICAID DIRECTOR FRESCATORE: All the services are still self-directed, including the ability to hire and train and retain or not retain your personal care assistant, who could be a family member or a neighbor.

ASSEMBLYMAN ABINANTI: But that's only if the managed care company will recognize those people.

MEDICAID DIRECTOR FRESCATORE: No. In

fact, we require all of our managed long-term care programs to have a consumer-directed program.

ASSEMBLYMAN ABINANTI: Okay.

Are we moving to the medical model? Are we going to do away with OPWDD and just put everything into Medicaid and go back to where we were years ago before OPWDD was put in there?

COMMISSIONER ZUCKER: Not that I know of, no.

ASSEMBLYMAN ABINANTI: Because it looks like we're working our way towards that. And it looks like we're working on the basis of applications for waivers; correct? What you have proposed is not yet approved by the federal government; correct?

MEDICAID DIRECTOR FRESCATORE: That's correct. There's a series of waivers that would enhance care management services --

ASSEMBLYMAN ABINANTI: Waiver applications.

MEDICAID DIRECTOR FRESCATORE: Waiver applications, right.

ASSEMBLYMAN ABINANTI: So one of the Senators asked you the question, what happens if it gets rejected? Are we going to be in the same situation that we've been in for years where the feds are trying to recoup monies that we never should have spent through Medicaid?

MEDICAID DIRECTOR FRESCATORE: No, the waiver -- what -- what we're referring to is different than the State Plan Amendment. The waivers would be for certain types of permissions for -- from CMS --

ASSEMBLYMAN ABINANTI: Right. But we're acting as if we had gotten them; correct? We haven't gotten them yet.

MEDICAID DIRECTOR FRESCATORE: No, we've not -- we've not implemented program changes for which we need federal approval through either a 1915(a) or (c) or 1115 waiver.

ASSEMBLYMAN ABINANTI: Well, but we're going to do it -- but it's proposed in the budget to do it anyway.

MEDICAID DIRECTOR FRESCATORE:

Contingent upon approval of -- I'm not certain what provision you're specifically referring to, but generally all of those program implementations are contingent upon federal approval of any necessary waiver amendments.

ASSEMBLYMAN ABINANTI: Now, we're going full speed ahead with Medicaid managed care for people with disabilities; correct? That's in the budget.

MEDICAID DIRECTOR FRESCATORE: It's a voluntary program. I mean, what the waiver is needed for is to require individuals to join. As a matter of fact some 20,000 or 30,000 individuals have voluntarily joined a managed care plan. That is --

ASSEMBLYMAN ABINANTI: Right, but others have not.

MEDICAID DIRECTOR FRESCATORE: -- permitted, and we've not moved forward with those.

ASSEMBLYMAN ABINANTI: Okay. Do you have a chart showing how many medical professionals by specialty and by region are

in or accept Medicaid payment, and how many are in managed care plans?

MEDICAID DIRECTOR FRESCATORE: We can certainly get you that information. It's available -- we'll aggregate it for you, but it's available online as well, where you can search by a provider or a a plan.

ASSEMBLYMAN ABINANTI: Well, we have people who can't find psychiatrists, we can't find social workers, we can't find all kinds of specialties for people with disabilities. They don't take Medicaid, and they're certainly not in managed care plans.

MEDICAID DIRECTOR FRESCATORE: We want -- we certainly want to know about those instances. Our agreement with the managed care plans requires that they make a provider available, whether they have an agreement or not.

ASSEMBLYMAN ABINANTI: Okay, I have two quick questions.

What do you do -- why does Medicaid not pay for out-of-state when there are no services in-state?

MEDICAID DIRECTOR FRESCATORE: We'd have to look at the specific services. There are instances where Medicaid does reimburse for out-of-state services. So we'd be happy to take a look at where your constituents are having problems with that.

ASSEMBLYMAN ABINANTI: The last question is you spoke about covering people up to 200 percent of the poverty level. The poverty level, as I understand it, for a single person is about $12,490 in the State of New York. I have a constituent who gave me a letter from Westchester County DSS which says that we will reduce your Medicaid coverage from a coverage spend-down requirement. You make $1250 a month from SSI, you've got to spend down to $859 a month. That's $10,300. So you're basically saying that person has to be poverty-stricken before they can get Medicaid services. Is that the policy of your department?

MEDICAID DIRECTOR FRESCATORE: So the -- no. Let me explain the federal rules and the state law on eligibility.

The 200 percent that we referenced was for individuals who qualify for the Essential Plan. There are different income levels for eligibility for different categories of individuals. And it could be that --

ASSEMBLYMAN ABINANTI: But basically this person has to be poverty-stricken before they can get Medicaid.

CHAIRWOMAN WEINSTEIN: Assemblyman --

(Overtalk.)

ASSEMBLYMAN ABINANTI: Can I get back on the second -- on the list, please, the second time around?

UNIDENTIFIED SPEAKER: No.

CHAIRWOMAN WEINSTEIN: We are -- we're going to go to the Senate now.

CHAIRWOMAN KRUEGER: Thank you.

And just for everybody keeping track, it's now 12:15 and we're on our first testifier. We've calculated that the second round is 3 minutes, and if you can use less, it's greatly appreciated. There may be an award. The two chairs -- the two chairs get 5 minutes, and if they can do less than 5,

they get extra points.

And I will ask you, since you have been sitting at that table since 9:30, if you think you can pull off another half-hour, we'll just start. If you need a break to go to use the men's or ladies room, we will respect that. Because we keep people here a long time. But we also know that --

COMMISSIONER ZUCKER: We're good.

CHAIRWOMAN KRUEGER: Okay. They're prepared to do a half-hour more of your best, toughest lightning-round questions, Assembly and Senate.

And for those in the hearing room and the hearing room across the hall, you're clearly grasping that based on where you are on the schedule, you may be here very late tonight. And at least the chairs are prepared to stay, but as we tried to explain when you signed up, because so many people wanted to testify, if you decide not to stay to testify, your testimony is still included. It is available to every member of the Legislature. It will be up online for

everyone to see. You will still have seven more days to submit it. And so if some of you think better now about wanting to not stay till 11 o'clock tonight, know that you have that option even if you've already checked in.

And some of you will find that later today you'll make that decision anyway --

(Laughter.)

CHAIRWOMAN KRUEGER: -- so I'm just making you -- I'm sorry, this is Day 8 for us in the budget hearings, and some of us have been in the rodeo a long time.

So with that, Senator Gustavo Rivera, chair of Health, five-minute max.

SENATOR RIVERA: I'm already a quick speaker, so I'm even going to be quicker.

One, General Public Health Work program. If you believe, as you said earlier, that measles is something that should be taken care of, right -- we're talking -- it is a communicable disease, is it not? -- then why would you go about cutting $27 million from General Public

Health Work programs that do, among other things, acute communicable disease outbreak, STD and HIV screenings, naloxone distribution? Tell me quickly why is that something that makes sense? For the City of New York.

COMMISSIONER ZUCKER: Well, the City of New York, as I mentioned before, the -- they can get resources from other areas. And so we're just trying to --

SENATOR RIVERA: That's an assumption that you're making, which is great, but that doesn't mean that they're actually going to get it. They can apply, but that doesn't mean they're going to get it. And also there's a hit that's actually two years, because their fiscal is different than ours, so their cut is not 26, it's actually like 50-something million dollars.

COMMISSIONER ZUCKER: We looked at that. I think it's the same year. We looked into that.

SENATOR RIVERA: I just got information from the city today that says

it's two.

This is how quickly I'm going to go, just so you know. So that one, the problem comes down.

Second, we're talking about fiscal intermediaries -- we talked about it, and a couple of my colleagues are probably going to say the same thing. If you truly believe that consumer directed programs not only save money -- because they do, and it actually provides for disabled individuals to be able to live a fuller life. Have you thought about how much the changes that you're proposing might impact the program in a way that might actually dislodge some of these folks that are -- without this program, they would not be able to actually live full lives?

COMMISSIONER ZUCKER: We'll look at it, yeah.

SENATOR RIVERA: That is -- that you have to -- okay.

I'm thankful, however, that we didn't have to -- I'm not sure why you all keep

doing prescriber prevails spousal support, we do it every year. Thanks, but no thanks. Just want you to know that -- I'm not sure why it's in there, but just so you all know.

I'm concerned about managed long-term-care plans, particularly -- we've talked a lot about ICS in particular. Guildnet also went out of business. Which certainly there is -- there has to be a concern about a high-need rate cell. We've talked about it a long time. I think it is absolute necessary, without these type of rate cells, the idea that long-term-care plans would be able to continue to exist. They're necessary as insurance plans, managed long-term-care plans, but they're just going out of business left and right because they have to take care of -- you know, the needs are so high. So a high-need rate cell is something I'd like you to consider.

I also, on the emergency transportation stuff -- a lot of my colleagues have also spoken about that. And I would just add that much like when we

talked about the CDPAP, the fiscal intermediary, or the issue of the case mix, please think through how this is actually going to impact people that are currently receiving the services. We all understand that we need to save money, we get it. But as we -- you know, in Spanish there's this thing, when I was in Puerto Rico, los baratas son el caro: The cheap things are sometimes very expensive at the end of the day. Like how do you -- not spending the money, not investing the money up front might actually have an impact, a negative impact.

Second -- this I do want you to respond to -- the Fidelis/Centene thing we talked about earlier, but I've been around here long enough to know that press releases don't really mean anything. So I want to know in what document -- you told us you did the breakdown of -- the percentage of how that's going to break down, what's going to go to nursing homes and hospitals, et cetera. Could you tell me where that is in an actual document like a budget document or like --

something like that?

MEDICAID DIRECTOR FRESCATORE: We will get that for you. From when it was in the State Register?

SENATOR RIVERA: Oh, wait, so there's -- okay.

MEDICAID DIRECTOR FRESCATORE: Yeah. And there was the State Plan Amendment as well for it.

SENATOR RIVERA: Gotcha. Something -- something that's like a hard thing.

MEDICAID DIRECTOR FRESCATORE: Yes.

SENATOR RIVERA: Okay, thank you.

And I know there was also a -- and last, and I know that probably Assemblymember Gottfried will add on to this as well -- as far as the access commission, the commission -- we talked about it briefly, there is -- while I could certainly ask you questions about how exactly it's organized, et cetera, and who are the people that are going to be on it and what have you, but it seems to me that -- it seems certainly to Assemblymember Gottfried and myself that it

has not -- for the record, it is not a really productive thing. We don't know exactly who's going to be in there.

There's no breakdown as far as whether there's going to be representatives from -- that can be appointed by the Legislature, folks that are representative of patients. It seems to us like it's just something that you want to put forward so you can say that you're kind of doing something about it and thinking about it, but not really.

So just for the record, not a fan. So -- yeah.

And last but not least, on the Essential Plan expansion, I know there's going to be conversations about it, I'd certainly -- the budget impact, the shortfall that was announced, again, magically yesterday when all of a sudden we have $2.5 billion or whatever it is that we couldn't -- that we didn't know we're not going to have. Obviously it impacts everything, and so it will impact that. But just as a five-second thing, certainly

consider how we're going to expand the Essential Plan to cover people who are not currently covered.

I tried to do the best I could.

CHAIRWOMAN KRUEGER: You're amazing. And you will make me pay the price later, Gustavo.

Okay, Dick Gottfried, can you speak as fast? Oh, I'm sorry.

(Laughter.)

CHAIRWOMAN WEINSTEIN: Yes, no extra points for Gustavo, but we have our money on Dick.

(Laughter.)

CHAIRWOMAN WEINSTEIN: Dick Gottfried, for his second.

ASSEMBLYMAN GOTTFRIED: I don't think I can speak as fast. But one thing on the universal coverage commission, I would suggest don't spend too much time explaining it to people, because I don't think it's going to exist in the budget when it's passed.

My friend Kevin Cahill likes to call

it the Gottfried Commission. I've got another name for it. But since we're in polite company, I won't share it with you.

I do want to ask just quickly about the Article 6 funding. Commissioner, you said the City of New York can get all this money from the federal government. Which would seem to suggest that you think the city is known for not grabbing every dollar it can get and that it is somehow negligently not applying for federal government funding. Nobody's known the City of New York to behave that way.

And so I'd like to know what funding is available to New York City that they're somehow sloppily not applying for. And wouldn't Buffalo and Rochester and Ithaca and everyplace else be able to apply for that same funding? And yet you're not socking them.

COMMISSIONER ZUCKER: No, actually -- actually -- well, the way I see this is that I have to look out for the entire state on this and to be fair on all the counties

upstate, downstate, and elsewhere. And the city does -- there are opportunities, and I will get back to you about the details of this, but the city can apply -- it's different than other parts of the state. They can get funding from CDC for different programs and projects. And I will get --

ASSEMBLYMAN GOTTFRIED: But somehow federal law says Buffalo can't get it?

COMMISSIONER ZUCKER: Well --

ASSEMBLYMAN GOTTFRIED: I've never heard of such a thing.

COMMISSIONER ZUCKER: The city -- there are certain programs that exist between the city that the CDC and other agencies support the city on. And we've seen this even for certain monies when -- I can't give you the details of it, but when there's a whole issue about bioterrorism, there's monies that went directly to the city. There was state money and then there was money specifically to that city and a couple of other cities.

But I can -- I will get you the

details --

ASSEMBLYMAN GOTTFRIED: So they're already getting that money.

COMMISSIONER ZUCKER: Well, there is -- there is -- there is money that comes in, yes, to the city.

But when I'm sitting there and I look at this and I say I've got 63 percent of the monies going to 40 percent of the state population, and I'm looking across the state and I realize there are other challenges in other parts of the state -- and when I mentioned before about the issue with measles, I sort of feel like I have to be sure that I'm able to provide them, other parts of the state, with the resources that they may not have another avenue of -- to get the money from.

ASSEMBLYMAN GOTTFRIED: Well, I --

COMMISSIONER ZUCKER: I will get you details --

ASSEMBLYMAN GOTTFRIED: I'd like to see a list of the funding that New York City is negligently failing to apply for and would

not be available to other localities to also apply for. And I'd also like to know whether, you know -- the Governor always talks about all the horrible policies of the Trump administration, and we're going to do it here in New York differently. I'm just wondering whether some of those horrible Trump administration policies would be incorporated into that federal funding.

(Inaudible cross-talk.)

ASSEMBLYMAN GOTTFRIED: -- certain populations that couldn't be aided.

COMMISSIONER ZUCKER: I'm not saying they're not applying, I'm just saying that there are monies that come into New York City from other avenues for health, and as the state commissioner, I'm sort of making sure that I don't compromise other parts of the state, whether it's -- you pick the city or even just counties that don't even have a major city in it that have needs, rural needs that we're trying to address.

So that's why, when we looked at the monies and said, okay, how do we do this --

ASSEMBLYMAN GOTTFRIED: And also show us documentation that it's not only -- that while the city may have 40 percent of the state's population, there are various health problems that as you well know are heavily concentrated in heavily urban areas and less concentrated in wealthier suburban areas or different areas. Sometimes that's a factor in public health. It's not just the number of human beings.

COMMISSIONER ZUCKER: I hear you on that. And just some of the things I have seen over the course of the past five years is that there are some of the challenges upstate that are unique to those areas that we -- you know, we don't see as much in more urban areas, so.

ASSEMBLYMAN GOTTFRIED: You're not giving those areas more money under the budget, are you?

COMMISSIONER ZUCKER: No, no, we're just --

ASSEMBLYMAN GOTTFRIED: No, I didn't think so.

CHAIRWOMAN KRUEGER: Thank you.

Dick Gottfried, you did very well.

(Laughter.)

CHAIRWOMAN KRUEGER: And Senator Gallivan, let's see how you can handle it.

SENATOR GALLIVAN: I don't talk fast, and I won't even try.

A couple of different things. First, there's a proposal in the budget to provide Medicaid for inmates 30 days prior to release, which I know is contingent on New York getting CMS approval for the federal share of Medicaid.

Two questions. How many individuals do you anticipate that this would cover? And secondly, will there be an additional cost for local governments, for county governments?

MEDICAID DIRECTOR FRESCATORE: As to the question, Senator, about how many individuals, we expect that it would cover about 100,000 individuals, including in state prisons and Rikers and in upstate jails {inaudible}. And we don't at this point

anticipate that there would be a cost to local governments, but we -- obviously you know, as we prepare this waiver amendment, we would meet with stakeholders and have conversations about what was included and how the funding would work.

SENATOR GALLIVAN: Okay, thank you.

CHAIRWOMAN KRUEGER: That's it?

SENATOR GALLIVAN: No, I have two more. But I'm still talking in like a normal tone of voice. You owe me 10 seconds, Chairwoman.

(Laughter.)

SENATOR GALLIVAN: You spoke earlier about increasing the age of tobacco use to 21 and, if I heard correctly, talked about research out there that's suggesting that led to decreased use from younger individuals. And I didn't know if you're aware, there's an American Journal of Public Health study that looked at New York City's increased minimum legal purchase age back in 2014, and the results of the study said, and I'm quoting, "The law did not reduce tobacco use in

New York City at a faster rate than observed in comparison sites."

I'm not even asking you to comment on it because of the time. If you're not aware of the study, I can provide it to you. But it's something for consideration as you pursue that age 21.

And finally, the Governor's proposed another study about safe staffing. You know that there's been legislation in both houses dealing with safe staffing in hospitals and nursing homes, and this year in the budget the Governor's actually proposed a study. What can you tell us about the study? What are your objectives, who will be a part of it, how will you make determination, timeline, all those things.

COMMISSIONER ZUCKER: Sure. So we're looking at both patient safety and quality with this kind of a study. We've put out a request to the hospitals to get data from them. We have data from nursing homes already, so that data is already within our system.

We are trying to figure out -- let me put it this way. The staffing -- there is no one simple answer on the staffing issues because having worked in hospitals, it's much different whether you're in one part of a hospital, what kind of services that you're asking someone to provide, whether it's critical care or whether it's on a regular ward or even in some of the other parts of a medical center.

So these staffing issues are not so simple. And I think sometimes people want to narrow it down to just a number, like this is how many nurses you need per patient. And so we're going to look at this, we want to get the information from the hospitals and get that done.

CHAIRWOMAN KRUEGER: I'm sorry, I gave you the extra 10 seconds.

SENATOR GALLIVAN: Thank you.

I just want to make sure, when you talk about the study, that you include all the stakeholders that are involved. So obviously the hospitals, nursing homes,

nurses --

COMMISSIONER ZUCKER: Nursing homes we have some of the data.

SENATOR GALLIVAN: -- patients.

COMMISSIONER ZUCKER: Well, I think that it should be as transparent and as much information as we can get.

SENATOR GALLIVAN: Thank you.

Thank you, Chairwoman.

CHAIRWOMAN KRUEGER: Thank you.

Assembly.

CHAIRWOMAN WEINSTEIN: So we've been joined by Assemblyman Ra.

And we go to Assemblyman Cahill for three minutes.

ASSEMBLYMAN CAHILL: Thank you. And I won't use my three minutes.

But Dr. Zucker, what I asked you to do was to give it some thought and perhaps during Mr. Raia's discussion of vaping you had a chance to wander off and think about it, as most of us were thinking of something else too.

(Laughter.)

ASSEMBLYMAN CAHILL: I would just ask if you've had a chance to review Assembly Bill 4738A from last session or any of its predecessors that go back to 1992 when you were either in preschool, med school or practicing medicine. I know that all happened within three years of each other, so --

(Reaction from panel.)

COMMISSIONER ZUCKER: That was very profound.

(Overtalk.)

ASSEMBLYMAN CAHILL: You know what, never mind.

(Further reaction.)

COMMISSIONER ZUCKER: This ties back to the vaping issue.

(Continued cross-talk.)

ASSEMBLYMAN CAHILL: Just to try to make this as quick as possible on behalf of our colleagues and you and everybody else here, this commission that in your testimony you indicated that you were looking forward to, doesn't the Assembly bill and the bill

that will probably be introduced this year that will look very much like the bill that Assemblyman Gottfried has been carrying literally since 1992, provide a good strong basis to start this discussion and investigation?

COMMISSIONER ZUCKER: You're talking about on the universal --

ASSEMBLYMAN CAHILL: Yes.

COMMISSIONER ZUCKER: -- coverage.

So I think that all the information -- when we move this forward, we need to get as much information as possible. And I understand, you know, Assemblyman Gottfried has looked at this for a long time. And we will take all that information and incorporate that in as well as we move forward on this.

And I know there's many different moving parts to this issue. And I just think that in order to do this the right way is to have, you know, a commission to look at this and whether it's to study it -- but to get as much feedback as we can. And to look at any

bills and everything that's been put out there.

ASSEMBLYMAN CAHILL: Is the intention to use the Gottfried plan as the basis of the study?

COMMISSIONER ZUCKER: I think at this point what it is, is that's -- what Assemblyman Gottfried has put forth is one component to look at and to read and to see what is there, and to hear from every other stakeholder about what their thoughts are. And I think that's the only fair way to do this.

ASSEMBLYMAN CAHILL: Thanks, Doctor. I have more questions but I want the points instead. Thank you.

(Reaction from panel; laughter.)

CHAIRWOMAN KRUEGER: Thank you.

CHAIRWOMAN WEINSTEIN: Senate.

CHAIRWOMAN KRUEGER: Senator Seward.

SENATOR SEWARD: I'll take your time, Assemblyman.

(Laughter.)

SENATOR SEWARD: I want to return to

the transportation issue. And this time I wanted to ask about the proposals to carve out transportation from the managed long-term care and the adult day healthcare homes. That would remove their ability at those facilities to coordinate their own transportation and turn it over to these transportation managers. And there have been concerns about the quality of service provided by these transportation managers in certain cases.

Is the level of service offered in your estimation by these transportation managers comparable to the transportation services that are offered by our nursing homes, adult day homes, and public transportation providers?

MEDICAID DIRECTOR FRESCATORE: So I would first say, Senator Seward, that on the managed long-term care, one of the concerns that we hear is most of the plans do use a transportation manager. And often healthcare facilities in a geographic area have to deal with multiple transportation managers, some

for individuals, you know, in one plan versus another, in fee-for-service versus in managed long-term care. And so there's more paperwork and more -- you know, people have to follow different instructions for different patients.

So I'm not aware of any managed long-term-care's plans generally having their own transportation providers. The adult day healthcare, my understanding is that there are a couple of methods where transportation is provided. But we feel that given our experience now with the transportation manager, they manage many, many rides, they handle as many as 34,000 calls a day for transportation requests, that quality would be equal.

SENATOR SEWARD: Are you aware of any measures and training that the state transportation managers take to ensure the safe transportation particularly of high-acuity patients?

MEDICAID DIRECTOR FRESCATORE: I would need to get back to you with more detail.

Certainly we have measures around the responsiveness to phone calls, reviews of when rides are reassigned so that, you know, if one transportation provider can't make the ride, if their person is being switched to another provider.

But we can get back to you with that series of measurements and performance requirements.

SENATOR SEWARD: Okay. Thank you. I'm going to slip in one more.

Switching to the New York State of Health marketplace, you know, when the original Executive order created the marketplace, it said it would be entirely funded by federal monies. Why is the state still funding operations at New York State of Health? And what is the advertising budget for the New York State of Health?

MEDICAID DIRECTOR FRESCATORE: So as you know, the federal grant dollars were for a limited period of time, and the marketplace was largely developed using federal grant dollars. The total cost of -- the

administrative cost of the marketplace is borne by the programs that people can enroll in. So for a good part of the cost, Medicaid and Child Health Plus, there is federal match. And that is as the Medicaid eligibility is transitioned in from the district.

The advertising budget -- if I have to refine this a bit, we will -- it is about $14.8 million for generally an open enrollment period. That includes all types of media, including the creative development of any advertising and the actual media buy.

CHAIRWOMAN KRUEGER: Thank you.

MEDICAID DIRECTOR FRESCATORE: Substantially less than some of our other state marketplace --

CHAIRWOMAN KRUEGER: Thank you.

Assembly.

CHAIRWOMAN WEINSTEIN: Thank you.

Assemblyman Raia.

ASSEMBLYMAN RAIA: Thank you. No dissertation this time, and I'll be very quick.

I have some questions and concerns from the folks that run the hospitals, so I'm just growing to throw six points out there. Whatever you can get to, great. And then otherwise maybe offline we can get to it.

Number one, the hospital funding cuts for potentially preventable admissions. Last year we did ER beds; this year we're doing inpatient beds. I'm not sure if we saved anything on the ER beds.

Number two, the Population Health Improvement Program elimination, PHIP, something that's very important to many of my upstate colleagues.

Number three, capital investment. There is nothing in the budget this year for hospitals. There was notably $725 million last year that hasn't been distributed yet.

Number four, statewide workforce support on the non-Medicaid side. Workforce makes up 65 percent of the total expenses in a hospital. They'd like to see some help on that end.

Number five, major academic Centers of

Excellence program elimination. Our teaching hospitals are very important.

And Dr. Miller, my constituent, would never forgive me if I didn't get this last one in. What are we doing with Health Republic? Are we going to add to that fund and get these outstanding bills paid?

Thank you.

COMMISSIONER ZUCKER: Sure. So I'm going to answer some of those.

Well, in no particular order, starting with the capital investment issue, we gave monies in previous capital investments, a lot, to the hospitals. And we recognize that the healthcare system in general, we need to make sure that we provide resources to all different aspects of this, whether it's primary care clinics, community centers that provide healthcare that are necessarily basically community health centers as well.

And so we are -- we don't want to favor one area versus another. Otherwise, the entire system won't improve, and that's what we're trying to achieve. So that was

one issue. It doesn't mean that the hospitals aren't important at all.

The academic centers I mentioned before, that I'm very supportive of them and recognize their needs that they have.

Statewide workforce, yes, this is why we're trying to figure out different ways to increase the number of health professionals in the state. And there was some other components of that that we could talk about afterwards in the interest of time.

On the population health, the PHIP elimination, yes, that I recognize, that is what we spoke about as well before. I have to get an answer to you about that.

And then on Health Republic, Donna, do you have the number?

MEDICAID DIRECTOR FRESCATORE: I think on Health Republic we would need to defer that question to colleagues in the Department of Financial Services who regulated Health Republic, and/or the Liquidation Bureau.

Quickly just on the hospital -- the proposal in this budget for hospital

preventable inpatient admissions and readmissions, we'd intend to work with the hospital industry to come up with peer assessments comparing one hospital to another for the purpose of investing in primary care.

ASSEMBLYMAN RAIA: Thank you.

CHAIRWOMAN WEINSTEIN: Senate?

CHAIRWOMAN KRUEGER: Thank you.

Last for the Senate, Senator Antonacci.

SENATOR ANTONACCI: Thank you.

I also would like to thank all the first responders, the paramedics and the EMTs and firefighters that have been in attendance today. Thank you for all your hard work. And the nurses. I married a nurse and also worked in a hospital for seven years to get through college, so I got enough knowledge to be dangerous.

I'm from Syracuse, New York. We've got a little bit of a rural area as we get away from the city center. It seems to me there might be a crisis building where the rural ambulance providers -- I believe that

there's been funding being cut out of this budget, approximately 3 million. Which seems kind of odd to me, as I believe it comes with matching funds, so they're actually losing $6 million. And that's -- I don't want to say it's free money, but we would think we would want to maximize any matching funds.

What do we plan on doing for rural ambulance providers and advanced life support providers in the rural area?

COMMISSIONER ZUCKER: So we are -- as I mentioned before, we're trying to get more people and more EMS and provide more services to them. We gave monies last year to this.

I have to figure out the details and maybe we could sit down and talk about some of the options that are out there, particularly in the rural areas of the state, about that.

MEDICAID DIRECTOR FRESCATORE: If I could, the rural ambulance proposal, that is only state money --

(Calls of "mic.")

MEDICAID DIRECTOR FRESCATORE: Sorry.

There's no -- there's not federal match on that. It's state money only.

The investment from the report will have federal matches.

CHAIRWOMAN KRUEGER: Thank you.

Assembly.

CHAIRWOMAN WEINSTEIN: Assemblyman Garbarino.

ASSEMBLYMAN GARBARINO: Just a couple more quick questions.

We talked about case-mix savings. Just -- is that savings, can that be retroactive? Can you go back and claw money back that's already been paid out, or is this only prospective in-the-future savings?

MEDICAID DIRECTOR FRESCATORE: This proposal is prospective. It would begin with the rate adjustment, I believe, in July. This upcoming July the new methodology would be applied.

ASSEMBLYMAN GARBARINO: Okay, great.

Two years ago the Governor vetoed a bill that increased the state supplement program for adult care facilities, saying

that it was supposed to be done in the budget. It's been now two years and we haven't seen an increase in that -- actually, I think there's only been two increases in 30 years. And now I think we're -- an adult-care facility is closing about one a month for the last 18 months.

Is there something that the department -- since we don't see it in the budget here of increases, is there something the department's going to do to help these facilities out?

COMMISSIONER ZUCKER: Let me get back to you on that, about that.

ASSEMBLYMAN GARBARINO: Okay.

Also, last, I just want to go back to the drug cap. How many -- since it's been utilized, since we've had DURB, how many drugs have gone in front of -- how many drugs has the department not been able to negotiate a new rebate on that it's had to go to the review board?

MEDICAID DIRECTOR FRESCATORE: I would have to get you a count of the number of

drugs -- we certainly can do that -- that have gone before the review board. It's in our public agendas. But we'll gather that information for you.

ASSEMBLYMAN GARBARINO: I think I've -- I've seen -- I did a little research and it looks like there's only been one, one that went for review. Do you know -- I think it was a cystic fibrosis drug.

MEDICAID DIRECTOR FRESCATORE: There's been other drugs that have gone before the Drug Utilization Review Board.

The instance that you're remembering is one particular drug where we are still working with the manufacturer to get them to agree to provide the state Medicaid program with rebates.

ASSEMBLYMAN GARBARINO: Okay. All right, thank you.

COMMISSIONER ZUCKER: Remember, that was the drug with an incredibly high price --

ASSEMBLYMAN GARBARINO: Yes.

COMMISSIONER ZUCKER: -- to it, right.

CHAIRWOMAN KRUEGER: Assembly,

continuing.

CHAIRWOMAN WEINSTEIN: Right.

Assemblyman Byrne.

ASSEMBLYMAN BYRNE: Thank you. I had to run out real quick before for a committee meeting. I just wanted to kind of clarify something mentioned earlier.

We were talking about the Medicaid program and the $74 billion. I just want to make it clear, I think there's a general agreement that we want to make the program run as efficiently and as effectively as possible, root out any waste, fraud or abuse, and empower people to get to work and earn more. And that was basically my point.

I hope that you do get an opportunity to review that legislation I mentioned, A9901A, from last year. It would call for a phased-in takeover of local costs, not just the growth. It would address some of the issues that we hear about when we're talking about the benefits cliff in the Medicaid program for people that receive it.

And I wanted to circle back to another

issue that we've already heard about a little bit, about the heroin and opioid epidemic. I believe in the past we've funded, the state in the budget, for OASAS, it was about $200 million. Is it the same this year, is that my understanding, is that correct?

COMMISSIONER ZUCKER: Let me take a look at the numbers here. I'll give you the exact dollar amount for this year on that as well. I know we've put a lot of money into the different areas of the opioid crisis, to tackle it.

ASSEMBLYMAN BYRNE: Okay. My question was related to if it's flat or if there's an increase.

And it's been mentioned before about the elimination of the EMT providers' supplemental payment, right, and that cost. One of the things I wanted to ask about is in our state budget, DOH supplies funding for naloxone and Narcan training --

COMMISSIONER ZUCKER: Right.

ASSEMBLYMAN BYRNE: -- and for services. Has any of that gone towards

ambulance providers to help offset some of the costs they may be seeing from increased uses of Narcan to save lives out in the field?

I mean, I myself worked and volunteered as an EMT and have been trained and used this. I know some things change year over year. Years back we were using EpiPens, now we're using check and inject. And as far as I know we're still using the same methodology and delivery for Narcan and basic life support in EMS. And I'm just wondering if the state is providing any additional funds or resources to help offset those costs.

COMMISSIONER ZUCKER: So we have $7 million for naloxone. And so let me see where those dollars are going. We've trained like 320, 330,000 people on this, so --

ASSEMBLYMAN BYRNE: That's a pretty -- that could be general public and --

COMMISSIONER ZUCKER: Right, that is. It's 60,000 were public safety personnel.

ASSEMBLYMAN BYRNE: Thank you,

Commissioner.

CHAIRWOMAN KRUEGER: Thank you.

Assembly.

CHAIRWOMAN WEINSTEIN: Assemblywoman Bichotte.

ASSEMBLYWOMAN BICHOTTE: Thank you again, Commissioner.

I first want to address the maternal maternity issue in terms of the mortality rate. As you may or may not know, in October 2016 I was pregnant at 5½ months and when I went to the doctor at Columbia Medical Center, they said that I was dilating at 3 centimeters. So I had to rush to Columbia Medical Hospital and when I got there, they said that my baby was coming out. So they gave me two options, to abort it or whatever. I said no, I'm not going to abort it, I will want to do everything I can to save my baby. And so the other option was to kick me out of the hospital.

So Columbia said because of hospital policies, we don't have any beds for you, there's other patients who are -- who need to

use this room, and we can't do anything for you. So after crying like crazy and having Haitian doctors calling and cursing out these doctors, we decided to leave because we were being pushed out, and we went to a local hospital in Brooklyn, Wyckoff Hospital, where the doctors received me well, did everything that they could. I was there for like four or five days. Unfortunately, I did deliver my son, Jonah Bichotte Cowan, but he didn't survive past two hours, and so deemed a stillbirth. He was premature, as I had something called "incompetent cervix."

So I say all this to say it says that the budget creates a board of experts in the Department of Health that will implement and enhance analysis to review every maternal death in New York State. I would encourage that you have people of color on the board, and to also address the disparity in black maternal mortality. When I was at Columbia, they didn't know I was an elected official. I didn't tell them that I was an elected official because I wanted to witness how they

would treat me as a black woman. And I almost died, and obviously my child died. I was not at the best care. I'm a victim, like the many black women who go through this.

So in the United States, black maternal deaths are three times white maternal deaths. In New York, it's four times. We here in the Assembly, in the State Senate, we formed a women of color task force to address these disparities, and we have some bills. So we want to know what this board will do in order to explore these options and how to address this.

COMMISSIONER ZUCKER: Assemblywoman, thank you for sharing your story. And I have to tell you, we have a maternal mortality team that has gone around -- we've gone around the state and I've had an opportunity to listen to six of these listening sessions all around the city and elsewhere. And I'll tell you, your story -- I have heard this story so many times about the disparities that exist -- in New York, but I'm sure it's across the country. And this is probably the

reason why the Governor has asked us to make sure that we tackle this and solve this problem.

And I assure you that the -- any committee that we put together will represent everyone, persons of color and everyone will be on that. Because what I heard from the moms in these sessions -- and their stories were really compelling. And I have had an opportunity to speak with some of the obstetricians, midwives about these issues, including only last week I was talking to one of the obstetricians about some of these issues and why this is happening.

So I assure you that we will get to the -- we will find the solution, we will solve this -- we will not have these kind of stories that happened to you, or for any other mom across the state -- and fix this.

So I appreciate your sharing that, and I guarantee that we will take this on.

ASSEMBLYWOMAN BICHOTTE: Thank you so much. And just to let you know that we do have a bill called the Jonah Bichotte Cowan

Law, in the name of my son, and we hope that the Governor and everyone, you know, embraces the bill to address some of these issues.

Thank you.

CHAIRWOMAN KRUEGER: Thank you.

And that's it for questioning for the Department of Health. So thank you for giving us four hours of your time --

COMMISSIONER ZUCKER: Thank you.

CHAIRWOMAN KRUEGER: -- or close to. And we will ask you to leave --

COMMISSIONER ZUCKER: Thank you.

(Laughter.)

CHAIRWOMAN KRUEGER: -- and you won't argue.

And as Troy Oechsner from the New York State Department of Financial Services replaces you -- I see a lot of movement, that's good, that's healthy. Just know there were probably about 20 MPC Tier 4 people who were in the Overflow Room, Hearing Room C. And I see quite a few people leaving.

So give us just a couple of minutes and then Overflow Room C people, you may find

that there is room to join us in hearing Room A. Hopefully not confusing the staff too much as many people leave, some more people might come over. Because now I'm seeing quite a bit of space as many people have to leave after hearing the commissioner of health. Or maybe they've just decided they're starving and need to go find lunch.

(Off the record.)

CHAIRWOMAN KRUEGER: So just for people keeping track over there in Hearing Room C, there is plenty of space in Hearing Room A if you want to come over, because apparently the show stopper was the commissioner of health, and he left and half the state left with him.

(Laughter.)

CHAIRWOMAN KRUEGER: Hi. Are you ready to join with us?

DFS DEPUTY SUPT. OECHSNER: I am.

CHAIRWOMAN KRUEGER: So Troy, I think I pronounced your name wrong, so if you wouldn't mind.

DFS DEP. SUPT. OECHSNER: My last name

is Osh-ner.

CHAIRWOMAN KRUEGER: Thank you very much.

DFS DEP. SUPT. OECHSNER: But with a name like that, however you want to pronounce it I'm good with.

CHAIRWOMAN KRUEGER: Hearing it will help me, thank you.

And you are the deputy executive superintendent for health within the Department of Financial Services?

DFS DEP. SUPT. OECHSNER: I am.

CHAIRWOMAN KRUEGER: And we have your testimony.

So the clock starts at 10 minutes. Feel free.

DFS DEP. SUPT. OECHSNER: Thanks.

Good afternoon, Chairs Weinstein, Krueger, Rivera, Gottfried, Breslin and Cahill, and all distinguished members of the State Senate and Assembly.

As you said, my name is Troy Oechsner. I'm the deputy superintendent of health insurance at the Department of Financial

Services, or DFS. I oversee the bureau that regulates commercial health insurance for the State of New York. I'm privileged to work for Governor Cuomo and our new acting superintendent, Linda Lacewell, and to serve all New Yorkers in this important role. Thank you for inviting me to provide an overview of the healthcare reforms in the Governor's Executive Budget.

DFS's mission is to protect New York consumers, strengthen New York's financial services industries, and safeguard our markets from fraud or other illegal activity. During the past year, at a time when our right to vital health insurance coverage has been under attack in Washington, DFS is focused on ensuring the continued strength of New York's health insurance markets and addressing such issues as women's reproductive rights, the opioid epidemic, mental health parity, and the launch of New York's paid family leave program.

Let me start discussing this year's initiatives by applauding our early

collaboration on contraception coverage. The Governor, in partnership with this Legislature, should be proud that the Comprehensive Contraceptive Coverage Act, or CCCA, was just passed on the anniversary of the landmark Roe v. Wade decision. The CCCA helps codify affordable access to contraception, including emergency contraception, for New York women.

New York has been steadfast in support of the Affordable Care Act, or ACA, which has made more affordable, quality health insurance coverage available to New Yorkers. Since the ACA, New York has cut the uninsured rate in half, and premium rates for 2019 for individual coverage are 55 percent lower than they would have been without the ACA, not counting federal premium tax credits.

New York's healthcare market continues to remain robust, with 14 issuers offering individual coverage, 19 insurers offering small group coverage, and consumers in every county having a choice of coverage. Unfortunately, the ACA has been under attack

by a hostile prior Congress and a current president who, although narrowly failing to repeal the ACA, did repeal the penalty for failing to comply with the individual responsibility requirements to purchase coverage.

A partial list of other attacks on the ACA include allowing expanded short-term junk plans that do not cover important ACA protections such as the ban on preexisting conditions exclusions and essential health benefits; encouraging association health plans that need not meet all ACA requirements and can cherry-pick healthier lives out of community-rated markets, making coverage more expensive for everyone else and undermining the stability of our markets; and allowing employers increased ability to deny abortion and contraceptive coverage.

In order to protect New Yorkers and preserve the successes of the ACA, the Governor's budget proposes to codify key ACA protections which ban preexisting condition limitations and annual and lifetime limits;

secure essential health benefits; improve prescription drug coverage by creating an exception process for consumers to access drugs not on an insurer's list of covered drugs; ensure that women have full access to medically necessary abortions without cost-sharing; prohibit discrimination based on sexual orientation, gender identity or expression, and transgender status; and ban limited benefit and other non-ACA-compliant junk plans.

Codifying the array of protections included in the Governor's budget will help ensure New Yorkers are not left out if the ACA is repealed or further undermined by acts of Congress or the Trump administration.

Now, the single largest driver of premium rate increases is pharmaceutical drug costs. Last year the Governor signed legislation that banned certain problematic pharmacy gag clauses in contracts by pharmacy benefit managers, or PBMs. These PBMs are intermediaries in the drug supply chain that have amassed tremendous power and influence

over the sale of pharmaceuticals. Despite playing such an important role in our health insurance market, they remain regulatory black boxes.

The Governor proposes robust regulatory oversight of PBMs, through licensing and examination, to ensure that PBMs are not engaging in unfair business practices and to set other minimum standards necessary to protect consumers and our markets. Two of the largest PBMs, CVS Caremark and Express Scripts, have committed to DFS not to oppose our bill.

The Governor's budget also proposes to increase coverage for fertility services to build upon the "Women's Agenda." In 2017, DFS instructed insurers that they must provide fertility services regardless of marital status, sexual orientation, or gender identity. In 2018, the Governor directed DFS to examine approaches for incorporating insurance coverage for in-vitro fertilization, or IVF, into the existing infertility coverage requirements. The

Executive Budget proposal expands access to coverage for IVF in large-group health plans.

The budget further requires coverage of fertility preservation, which is a process of saving eggs and sperm, for women with certain health conditions, including cancer, in large group, small group, and individual health plans. And the budget includes nondiscrimination language to ensure that New Yorkers have access to these vital services regardless of marital status, sexual orientation or gender identity.

The opioid epidemic has impacted every corner of the state, hurting individuals, families and communities. Under the Governor's leadership DFS, along with our sister agencies, have used our regulatory authority and worked with you in the Legislature to expand access and remove barriers to treatment and recovery services covered by health insurance.

Among other actions this past year, DFS issued a regulation that requires health insurers to establish a formulary exception

process so consumers can access addiction-treatment medication not on the insurer's list of covered drugs.

The Governor's current budget builds on these proposals and past successes. First, the budget bill codifies the federal Mental Health Parity and Addiction Equity Act. In addition, the budget includes a series of initiatives to further combat opioid addiction by, among other things, eliminating even more insurance barriers to accessing care, including reducing copayments and coinsurance as well as more robust parity disclosure and enforcement requirements. With the additional resources needed to conduct this increased enforcement, DFS, in partnership with our sister agencies, is eager to become a national leader in enforcement of mental health parity and addiction equity.

DFS is proud to be an important part of the Governor's budget initiatives to build on our past successes. We look forward to working with you in the Legislature on

reforms to increase access to affordable, quality health insurance coverage. Thank you for the opportunity to outline some of these key proposals in the budget, and I look forward to your questions.

CHAIRWOMAN KRUEGER: Thank you very much. The first questioner is Senator Diane Savino.

SENATOR SAVINO: Thank you.

I want to speak about the issue of IVF coverage. So again, it's a bill that I've carried along with Assemblywoman Simotas in the Assembly, and I'm happy to see the Governor is taking another one of my really good ideas and putting it in the budget, although he's narrowing it down to just large groups for IVF coverage.

Happy to see that we're extending coverage for fertility preservation to all carriers. But last year, in an effort to move this issue along, we had requested that DFS do a study on this to determine what the actual cost would be. Because as you know, the state workforce and local governments

provide this level of coverage through their health plans, the municipal workforce does, and some large employers do. So what we wanted to see is what would the cost be.

We have yet to receive that study. So is it possible you could shed some light on what the study showed?

DFS DEP. SUPT. OECHSNER: The study should be released imminently. We hired Wakely -- as you know, state contracting is a bit challenging, but we hired Wakely Consulting, and we're finalizing that report and it should be released really soon.

SENATOR SAVINO: I hope to see it soon.

Minimally we could look at what NYSHIP -- what it costs NYSHIP, because as I said, the state workforce already has this coverage.

One of the concerns that has been raised about creating a program where every insurer will cover it, there would have to be some level of a cap on the benefit to contain the cost. Some have suggested we're looking

at $50,000 or $55,000. I'm not sure how that would work. I'm more concerned that we put a hard cap on it.

Right now, as you know, it's expensive even for those who have it. One of the things that is equally expensive is the cost of the drugs and the fertility drugs. Most patients, from what I've been told by pharmacies that provide these drugs, is they pay for it out of pocket because there's a significant rebate program from the pharmaceutical companies to reimburse and to drive down the cost of the drugs.

If we include the cost of drugs in the benefit, it's going to seriously impact the number of rounds that you can go. So let's say you have a $50,000 benefit; $12,000 of it is drugs. That cuts into the benefit.

So is there a possibility that we could back the drugs out of the coverage and find another way to provide coverage for them or a reduction in the cost? Because it doesn't make any sense to create a new benefit and then you only get to use it once.

DFS DEP. SUPT. OECHSNER: Well, the proposal that's in the Governor's budget has a three-cycle proposal and includes all of the related expenses. I guess discussions about what -- how to alter that could, you know, all be discussed as part of a dialogue on this.

SENATOR SAVINO: So he's not suggesting a cap on the dollar amount of the benefit.

DFS DEP. SUPT. OECHSNER: Well, a three-cycle limit, not a dollar cap.

SENATOR SAVINO: You know, obviously this is a little bit more complicated than we have time to discuss. But I would like to have a discussion with you offline about what that might look like. Because again, if the cost of drugs eat up half of the benefit, we're not really going to be able to provide the kind of opportunities for families right now -- all families -- to be able to access fertility services in a really profound way that would help them.

DFS DEP. SUPT. OECHSNER: I'm happy to

have that discussion, yeah.

SENATOR SAVINO: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Assembly.

ASSEMBLYMAN CAHILL: Assemblyman Cahill, do you have any questions? Yes, I do. Thank you for asking.

(Laughter.)

ASSEMBLYMAN CAHILL: Hi, Troy, and welcome back. Having worked with you before during transitions, I know that in addition to your regular duties, this is the most stressful part of your job, so I'll try not to add to that stress. I have a couple of questions in a couple of different areas. I'd like to just start by following up on Senator Savino's questions regarding IVF.

The Governor proposes three courses as a limit, only large groups, and fertility preservation is not limited to large groups. So my question with regard to each of those components is why.

DFS DEP. SUPT. OECHSNER: It's a great question, and thanks for asking. And it's

actually a pleasure to come and discuss all this.

ASSEMBLYMAN CAHILL: You're the only person that thinks that, Troy, but go ahead.

(Laughter.)

CHAIRWOMAN KRUEGER: We could test that out for you.

(Laughter.)

DFS DEP. SUPT. OECHSNER: Well, the reason that IVF coverage is being proposed to limit it to the large group coverage for now is to avoid any risk of a fiscal impact.

And as you may know -- and we've had a hearing, and we've discussed this in the past -- that under the Affordable Care Act, if a state enacts a new benefit mandate, it has to pay for it out of state-only dollars. And that applies to anything that impacts essential health benefits under the ACA, which apply to individual and small group. There's no essential health benefits or EHB requirement for large group, so a new mandate on the large group does not trigger a state fiscal.

ASSEMBLYMAN CAHILL: So that was the reason, it was to avoid what the department believes would be a fiscal impact.

DFS DEP. SUPT. OECHSNER: Well, it would be a risk of the fiscal, I think.

ASSEMBLYMAN CAHILL: Right. Because I don't necessarily agree with you that it would be a new benefit.

As you know, we've demonstrated a great deal of constraint in the Assembly -- and I'm sure the Senate, even with the new majority, will do the same -- with introducing new benefits, but instead seeking only to clarify existing benefits.

And there is a benefit for IV coverage. And what is proposed both in Assemblywoman Simotas's bill and in other pieces of legislation are basically clarifications or definitions of that.

So separate and apart from the issue about a potential state charge as a result of increasing the benefits, then why was that not also the case with fertility preservation?

DFS DEP. SUPT. OECHSNER: It's a great question. And I think the difference is the way New York State law is drafted.

With fertility preservation, there's at least a strong argument that it's not a new mandate because it's just part of the general infertility benefits and we're just specifying that as part of those general infertility benefits that predate the ACA.

ASSEMBLYMAN CAHILL: So you're distinguishing it from IVF.

DFS DEP. SUPT. OECHSNER: Well, the difference is when you look at the Insurance Law provisions around IVF, there's a very specific exclusion of IVF coverage which certainly increased the risk of it being viewed as a new benefit mandate, since you'd be going against a specific exclusion of IVF coverage.

ASSEMBLYMAN CAHILL: So knowing what we know about people receiving IVF therapy -- that oftentimes, because their coverage is limited, they sort of cluster that coverage all at once -- what was the thinking behind

limiting it to three courses?

DFS DEP. SUPT. OECHSNER: I think it was, as you'll see when we release the report, we looked at -- Wakely looked at, with us, a range of different options, and that seemed like a middle ground. It was roughly consistent with what state employees are currently getting under NYSHIP, the New York State Health Insurance Plan. And so that was sort of the reason.

And we didn't want to put a specific dollar limit in because in the event that we do find comfort with extending this to IVF coverage to individual and small group, having a specific dollar limit as part of your required benefits is problematic with the ACA.

ASSEMBLYMAN CAHILL: Let's move on to ACA conformity.

Troy, in your testimony and also, as was noted, the thing that has changed mostly with the federal ACA, the thing that if we're looking to protect ourselves prospectively from things that might change in the ACA, why

have we not included the individual mandate as part of what the state is seeking in ACA conformity already, since that has been identified as a major issue in the continued success in expanding enrollment?

DFS DEP. SUPT. OECHSNER: It's certainly, you know, something that we've noted. I think at this point we've actually seen some increase in enrollment in the -- certainly on the exchange and -- you know, for individuals. So I guess we're not saying that the -- the impact to the New York markets may not be as devastating as we thought, but, you know -- and it's not in the current budget.

ASSEMBLYMAN CAHILL: In your written testimony and again in your oral testimony you pointed out the six areas or generally you pointed out six areas of ACA compliance and conformity that the Governor was seeking in a budget bill. My review of those is that in one fashion or another they are already the law of New York State, and in most instances statutory law of New York State.

What is the need to do it all over again, or is it just putting a Cuomo brand on a product that's already on the shelf?

DFS DEP. SUPT. OECHSNER: Really it's about trying to protect New York consumers against the possibility that the ACA could be repealed, which we saw almost happen. And --

ASSEMBLYMAN CAHILL: But we had several of those provisions before the ACA. The passage or not passage of the ACA didn't impact those aspects of the law in our state, where they may have in other states.

DFS DEP. SUPT. OECHSNER: Well, so, for example, preexisting conditions or the ban on annual and lifetime limits.

ASSEMBLYMAN CAHILL: In '98 I think we passed that.

DFS DEP. SUPT. OECHSNER: Well, actually preexisting conditions were allowed pre-ACA, and we -- what we've done is codify it in such a way -- as you may recall, we did work with you in the Legislature to do a big ACA -- we called it the ACA fix-it bill, back in 20 -- after the ACA was passed but before

2014, and we put a number of ACA provisions in the law, but many of them were subject to and specifically referred to the existence of the ACA. So the concern is if the ACA is repealed, those provisions and protections in New York law could be impacted.

Part of what this bill does is take away those references and dependency on the existence of the ACA to make them independent that will survive any repeal of the ACA.

ASSEMBLYMAN CAHILL: Okay, we used eight minutes on two points, I have eight points that I have to --

DFS DEP. SUPT. OECHSNER: Oh, sorry.

ASSEMBLYMAN CAHILL: -- get in in two minutes now.

(Laughter.)

ASSEMBLYMAN CAHILL: PBM regulation, just a very general question about it. The Governor has booked $43 million and change as a revenue or a cost savings as a result of PBM regulation. Can those cost savings be earned or those revenues earned without actual regulation of PBMs? And if not, why

not?

DFS DEP. SUPT. OECHSNER: Well, we think that PBMs in particular with the bill that we're talking about on the commercial market will give us a huge insight into this black box of entities that are huge players in the pharmaceutical market, and --

ASSEMBLYMAN CAHILL: But you've identified a dollar amount that's relatively specific, so it can't be that dark inside that box.

DFS DEP. SUPT. OECHSNER: We really think that getting -- shedding that light on PBMs will definitely help increase transparency --

ASSEMBLYMAN CAHILL: So it will help, but my question is, is it necessary to get that revenue or that cost savings?

DFS DEP. SUPT. OECHSNER: So my understanding is yes, it is necessary.

ASSEMBLYMAN CAHILL: Okay, maybe you can send me a note explaining why.

DFS DEP. SUPT. OECHSNER: We can talk about it more offline.

ASSEMBLYMAN CAHILL: Okay. So next I'll skip my fourth question and move on to an update on long-term care insurance and what we've done about it in the last 12 months since your former boss was sitting at the table and we had that discussion.

DFS DEP. SUPT. OECHSNER: Right. So as you know, long-term-care insurance is a perennial problem going all the way back many years. And what we've been doing in the past year is really looking at rates that plans have been -- long-term-care plans have been coming in with. We're really mindful that any rate increase for people who are purchasing long-term-care insurance is a major imposition, and so we've been doing landing spots, in many cases, where actuarially justified rate increases are needed to protect the solvency of those companies and preserve those benefits. And so those landing spots give the consumer an ability to trade off some benefits in exchange for lower premium rate increases.

ASSEMBLYMAN CAHILL: Thanks, Troy.

On Round 2 I'm going to ask you non-health-related questions, so just so you're aware. Thank you.

CHAIRWOMAN KRUEGER: Thank you, Assemblymember Cahill.

Senator Seward.

SENATOR SEWARD: Troy, good to see you again.

DFS DEP. SUPT. OECHSNER: Good to see you too.

SENATOR SEWARD: I was pleased to hear you say that the IVF study report is imminent in terms of its release, because it just seemed a bit backward to me to have the Governor's proposal included in the budget prior to the report being issued. We will, as a Legislature, need that information in terms of making a determination.

But as part of that report, will we be given information regarding the impact on -- that this new insurance mandate would have on insurance premiums?

DFS DEP. SUPT. OECHSNER: The report does look at impact and cost overall as well

as per-member per-month cost. So, you know, breaking it down on what we expect for the different markets -- individual, small group and large group -- so that we'd expect that information.

SENATOR SEWARD: As a longtime proponent of the commission to look at mandates in the health insurance area, I think it's important that we do that, and I'm glad that that study will do that.

Just very -- other questions that I had have been asked by others, but one final question that I would have, is there any update at all on Health Now and also the effort to try to get some of the medical providers some payment for services rendered?

DFS DEP. SUPT. OECHSNER: I think you mean Health Republic.

SENATOR SEWARD: Oh, I'm sorry, yeah, I'm sorry.

DFS DEP. SUPT. OECHSNER: Health Republic is with the Liquidation Bureau. There was a report that was filed -- it's available online. We can, if you don't have

it, make sure that you get it -- but I believe it was in November, kind of summarizing where it's at. The Liquidation Bureau is trying to go through -- they are going through their process of collecting all potential revenue to get into the pot that will then be distributed to the various providers.

And, you know, I understand it's a lengthy process, but it is with the bureau and they are actively working on it.

SENATOR SEWARD: Very good. I'm glad you corrected me, I misspoke there, because Health Now is not in liquidation.

DFS DEP. SUPT. OECHSNER: Yeah. Yeah.

SENATOR SEWARD: Thank you.

DFS DEP. SUPT. OECHSNER: Sure, yeah.

CHAIRWOMAN KRUEGER: Thank you.

Assembly.

ASSEMBLYMAN CAHILL: We'll go to the ranking member of the Insurance Committee, Mr. Garbarino.

ASSEMBLYMAN GARBARINO: Thank you, Chairman. You actually stole half of my

questions, so just bear with me.

I want to go back, though, about the IVF and the increased coverages and the effect on premiums. I know Senator Seward brought it up, but in addition to IVF we have the Contraceptive Coverage Act, increasing coverage there, and there's several other parts of this budget that are increasing coverages by large-group plans.

Was there any consideration given to what this is going to do to premiums for members?

DFS DEP. SUPT. OECHSNER: Absolutely. We at the Insurance Department -- or the Department of Financial Services, we receive complaints from consumers, from businesses, about rate increases every year, and so it's something we're very conscious of.

Just to clarify, in the Contraceptive Coverage Act, really it didn't extend coverage more than what we currently require by regulation for -- in most areas of contraception. We currently require coverage of contraception with no cost-sharing. We

did that by regulation. So that wouldn't have a new impact -- that piece of it wouldn't have a new impact on rates.

But as to IVF, you know, certainly it's in the mix of all the things that we considered. I'm trying to get the right balance of impact on affordability for businesses and individuals on one hand and important benefits on the other.

ASSEMBLYMAN GARBARINO: And I understand that. In your opening testimony you talked about how many different insurers are in New York State right now. And I'm just concerned, you know, with all these expanded coverages in the budget that premiums are going to increase and, you know, people -- insurance carriers might decide to leave. You know, we might not be as robustly -- you know, people participating.

So I think there's got to be a hard look, especially when that study comes out, at what IVF and all these other coverages are going to do to premiums. Because to ask us to just approve these without considering

that, especially with the study not out yet, I think is -- I think we're putting the cart before the horse here.

But another question about -- there's changes to the behavioral health, mental health and substance abuse -- you know, the state's putting it in to make it in parity with federal standards, is that correct?

DFS DEP. SUPT. OECHSNER: Correct.

ASSEMBLYMAN GARBARINO: It's just doing that -- it's going to be strict parity, there's no -- we're not doing any -- going any further here with coverage or --

DFS DEP. SUPT. OECHSNER: So the bill does -- as you say, one of the things it does is codify the federal Mental Health Parity and Addiction Equity Act. So that's going to be preserved in New York law if there's any changes on the federal law.

But in addition there are some pieces that do go beyond strict parity, and most of them are in the area of opioid and addiction treatment. So for example one of the things that goes beyond pure parity is that our

partners at OASAS, the Office of Alcoholism and Substance Abuse Services, have heard that copayments for people who are going to multiple visits in a day, often in the beginning of treatment, you know, they need to go to numerous visits, that those copayments and coinsurance can be a barrier.

And so one of the things that's being proposed is to limit those to one cost-share a day instead of having to do multiple ones, to try and increase access in that regard.

There's some other reforms -- I don't want to take up too much of your time. I'm happy to talk to you offline.

ASSEMBLYMAN GARBARINO: Okay. Thank you very much for that.

And just over to the PBM -- I might have to come back on this, but there's registration, there's licensing you're doing and everything's -- we're looking to, under the budget, I guess to start by January 1, 2020. So is the Governor -- or does the state already have some ideas of what it would like to look at in regulations? Are

you basing it on other states? I know other states have put in laws, you know, Arkansas, for example, put in a heavily regulated PBM bill.

What are you basing this on? I think to get it done in eight months is going to be pretty difficult, so.

DFS DEP. SUPT. OECHSNER: It's a great question. And what the PBM law would do is have an initial registration period for 2020, with the ability for us to look inside the black box, to examine and get information. And then the following year, in 2020, there would be an actual licensure requirement, which is more rigorous, as well as then give us the ability to come up with minimum standards based on the information that we've gleaned from looking into the black box.

ASSEMBLYMAN GARBARINO: Okay. Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Hi. I'm going to call on myself. Good afternoon.

DFS DEP. SUPT. OECHSNER: Good

afternoon.

CHAIRWOMAN KRUEGER: Actually, sticking with the pharmacy benefit managers, there seems to have been quite a bit of news stories about scandals. And I guess the best way I could describe the way I read them, it's sort of a kickback scheme in pricing and in some of the pharmacy benefit managers and some of the large pharmacy chains who might actually own them.

What can DFS do as far as investigating and doing something about that as a -- I'd say a sub-issue within the bigger issue of PBMs?

DFS DEP. SUPT. OECHSNER: Well, certainly passing this bill, which would give us the ability to directly regulate the PBMs, would be a huge help in giving us some insight into some of those potentially problematic practices around how rebates are done -- certainly the industry claims that they're saving lots of money for consumers and insurers and employers.

But giving us the ability to really

look and see how much of those rebates are really getting passed along, what is the deal with those contracts that they have with various pharmacies and the drug intermediaries, it would be important.

CHAIRWOMAN KRUEGER: And given I guess last year's attempt by the Governor to rein in some prices with pharmaceutical companies themselves and then I guess a lawsuit that concluded that wouldn't work, do we think this is enough to actually address the problem of the -- it just seems exorbitant -- growth in certain drug costs?

DFS DEP. SUPT. OECHSNER: Well, you're absolutely right, drug costs -- we get the rate requests from insurers, and drug costs are the leading piece that is driving those increases. And I would not say that passing this PBM bill is the answer to all of our issues, but we think it's one important piece.

CHAIRWOMAN KRUEGER: Thank you.

A topic that didn't come up in your testimony is the issue of the long-term-care

insurance companies who were selling products for many, many years, often under a state-approved regulated program. I forgot the name of the program, so --

DFS DEP. SUPT. OECHSNER: Partnership for Coverage?

CHAIRWOMAN KRUEGER: Thank you very much. And then watching as the number of people who had bought the insurance coverage was literally hitting the age where they would all be drawing it down. You saw the insurance companies either start to pull out of the market completely and drop their plans or demand very high increases in the rates while decreasing the benefits on the existing coverage.

I actually thought it was this giant bait-and-switch, personally, because they all knew for 25 years that the statistics were showing, yes, that people were living longer and they weren't going to die before they used this. And I felt like I'm not an actuary and I knew this was happening, so how come every insurance company in the country

didn't?

So have we gotten our arms around this problem now? Has it balanced out or are we just losing all of them and the people who paid that money have nothing?

DFS DEP. SUPT. OECHSNER: So that's a really good question, and it -- the answer -- I can't give you a one-sentence answer. But the reality is that insurers as well as regulators, not just in New York but around the country, I think it's fair to say mispriced these products, priced them too low, because -- there were a number of things. It was a new product some years ago, they have a long tail, meaning they take -- people pay into this for a long time before they use the benefits, and we've had a sustained period of low interest rates. The lapse rates -- meaning how often people let their coverage go -- is much lower than everybody assumed, both the insurers and the regulators, not just in New York but everywhere. And as you said, medical advances, people living longer than some of

the assumptions that people were making at the time. All of those contributed to rates being inadequate.

And I'd say New York, like a number of other states, didn't want to raise rates prematurely because once you raise the rates, again, it's a long tail, it's -- consumers are stuck with those rate increases for a long time. So we've all been very cautious as regulators, but we've come to the point where in some instances some large rate increases have been necessary to keep the insurers solvent.

CHAIRWOMAN KRUEGER: And yet a bunch of them were closing. How many are left that are actually -- is anybody selling these products now?

DFS DEP. SUPT. OECHSNER: There absolutely are still insurers who are selling the products. I don't have the number off the top of my head of how many insurers are -- remain with active products. But I can get back to you on that.

CHAIRWOMAN KRUEGER: Well, is there a

way for us to as -- or DFS to let people know that at least when looking at this product, buyer beware? Because I know my district is filled with people who believed that this was what they should do for their old age and they had the disposable income to buy the insurance, and then they poured into my office with -- when they're in their eighties, being told they had to face a 60 percent increase in premiums, which they know they can't pay. And so then their decision is do they figure out how to keep paying or do they lose what could be 20, 25 years of investment in insurance just as they're actually at the point in their lives of needing it.

And I hate to imagine that we the State of New York are continuing to allow people to get sucked into an insurance that simply, if it continues the way it has, won't be there for them when they need it.

DFS DEP. SUPT. OECHSNER: Well, we do have disclosure requirements on the sale of these products. Happy to, you know, offline

review those and discuss whether you have any thoughts on how we could improve that.

One of the things we're trying to do is to make sure, going forward, that they're priced properly so that we're not faced with the same issues that we've had in the past on this.

CHAIRWOMAN KRUEGER: Thank you.

DFS DEP. SUPT. OECHSNER: The only thing I would just add is that we get it. I know people who have had big long-term-care rate increases, and they talk to me at parties, and a lot of them don't have the means to do this easily. And that's one of the reasons why when we've absolutely had to do it, we've come up with those landing spots that allow consumers to trade off some amount of reduction in benefits for less rate increases.

CHAIRWOMAN KRUEGER: I don't know if I would tell people what you do for a living at parties, but --

(Laughter.)

DFS DEP. SUPT. OECHSNER: You'd be

surprised.

(Laughter.)

CHAIRWOMAN KRUEGER: Thank you very much.

DFS DEP. SUPT. OECHSNER: You're very welcome.

CHAIRWOMAN KRUEGER: Assembly.

ASSEMBLYMAN CAHILL: Mr. Raia.

ASSEMBLYMAN RAIA: Thank you, Chairman.

Thank you for joining us today.

I just want to drill down a little bit further on the Health Republic issue. Your former boss knew my constituent Dr. Miller very well. I'm sure you probably might even know him too. Imagine the phone calls I get.

Needless to say, I know we liquidated, we're now going after the insurance policies. There can be no doubt we're not going to recover all of the losses. So does New York State stand poised to backfill and add to that fund to ensure that all the providers are made whole again?

DFS DEP. SUPT. OECHSNER: You know,

that's a discussion that I think will have to ensue. And I think we've all -- I can't speak for everybody. I think the general discussion has been let's see what we're dealing with first at the end of the day, and that's what the Liquidation Bureau is looking at.

ASSEMBLYMAN RAIA: Do we have an idea when the end of the day is?

DFS DEP. SUPT. OECHSNER: I don't personally. I can't predict a specific date. I know it's -- there's litigation involved, and that often doesn't --

ASSEMBLYMAN RAIA: All right, thank you.

Second question, with respect to codifying the ACA. One of the biggest complaints I've heard from small businesses when we did that is -- well, not -- before we did it with the ACA, essentially eliminated small group policies for businesses with less than I guess 50, now it's 100 employees. By codifying it, are we basically going to say that, well, we're never going to go back and

let you offer a small group policy for these businesses? They're hurting. Fifty employees, 75 employees, what have you, is still a big burden for them to shoulder, and if they have the ability to link up with other small businesses there's -- you know, it could be a good thing for them.

But I'm worried by codifying the ACA, we're never going to be able to get back to those days again.

DFS DEP. SUPT. OECHSNER: So if you're talking about -- it's already in state law that we've increased the group size from 50 to 100, and the idea of that was to try to increase the risk pool for small businesses, which we know are the engines of growth, to try and make it more affordable for that. And it has had some benefit.

As you may know, we did a report a little while ago with Milliman Actuarial, and basically found that if we would repeal that and go back to a small group size of 50, it would have a negative impact on a very broad number of the existing small groups but it

would have a positive effect on a small number -- and in some cases a very positive effect on a small number of those 51 to 100 larger small groups. So it's a balance, it's a tradeoff.

ASSEMBLYMAN RAIA: It is. But those small businesses, that group is the backbone of our economy when you take a look at it. It's small mom-and-pops, you know, with less than 50.

DFS DEP. SUPT. OECHSNER: Absolutely.

ASSEMBLYMAN RAIA: All right, thank you. I appreciate it.

CHAIRWOMAN KRUEGER: Thank you.

Assembly continues.

ASSEMBLYMAN CAHILL: We will continue with the chair of the Health Committee, Mr. Gottfried.

ASSEMBLYMAN GOTTFRIED: Just a couple of quick observations. One is that the answer -- the better answer to almost every question you've been asked, of course, is pass the New York Health Act.

(Laughter.)

ASSEMBLYMAN GOTTFRIED: But on the question of conversation at parties, I just want to observe, you know, you and I have worked together for quite a number of years. And while your work may or may not make scintillating party conversation, I think your work is something that you can be really proud of --

DFS DEP. SUPT. OECHSNER: Oh, thanks.

ASSEMBLYMAN GOTTFRIED: -- in discussion at parties or anywhere.

DFS DEP. SUPT. OECHSNER: Thanks.

ASSEMBLYMAN GOTTFRIED: You're welcome.

ASSEMBLYMAN CAHILL: Well, with that, we'll go right to Will Barclay.

(Laughter.)

ASSEMBLYMAN CAHILL: I don't know how I'd top that.

ASSEMBLYMAN BARCLAY: Thank you, Chairman. And Troy, nice to see you.

Just following up on some of the questions earlier about the federal essential health benefits, have they penalized any

states so far going -- or New York -- maybe New York State's been penalized for overstepping the mandate requirements?

DFS DEP. SUPT. OECHSNER: That's a great question. And we didn't know the answer and we couldn't find any examples of any states, so we called the NAIC, which is the National Association of Insurance Commissioners, it's our national association. And their main staff person, Brian, said he's not -- he surveyed and didn't find any state that has been penalized specifically for instituting a new mandate.

ASSEMBLYMAN BARCLAY: Okay, thanks. That was more a curiosity question than anything.

You heard a lot with some of the repeal of the ACA and the federal government about health savings accounts and how they potentially could lower the cost of health insurance. Are they used much in New York State? And are you guys encouraging use of health savings accounts?

DFS DEP. SUPT. OECHSNER: We have

specific plans that are health savings account compatible, so that people can use those tax advantaged accounts. And we're certainly not against using those tax savings if that's, you know, something that employers and employees want to do.

ASSEMBLYMAN BARCLAY: You don't have any idea of, you know, the percentage of people that use those compared --

DFS DEP. SUPT. OECHSNER: I don't know the precise number off the top of my head, but we can get back to you on that.

ASSEMBLYMAN BARCLAY: All right, thank you. Thank you, Chairman.

ASSEMBLYMAN CAHILL: Thank you, Mr. Barclay.

Mr. Ra.

ASSEMBLYMAN RA: Thank you, Chairman.

I want to go back to the PBM issue. You know, I know that the language is fairly broad, which is -- I think will allow the department to act in terms of getting information which is a positive thing. And the transparency obviously is something that

many believe is much needed.

But I just wanted to ask with regard to -- there's been a couple of bills kicking around the Legislature for a few years regarding this area and in particular some of the transparency bills also tried to hit on other topics like retroactive claim denial and things of that nature. Is the department looking at that issue as well?

DFS DEP. SUPT. OECHSNER: The issue of retroactive claim denial specifically?

ASSEMBLYMAN RA: Yeah.

DFS DEP. SUPT. OECHSNER: So explain exactly what -- you mean, in other words, doing audits of claims --

ASSEMBLYMAN RA: Yeah.

DFS DEP. SUPT. OECHSNER: -- that have already been paid?

ASSEMBLYMAN RA: I had a local pharmacist last fall just have me come in just so -- you know, just to kind of give me a flavor of some of what he deals with. You know, it's like: I lost money on this transaction that I did a couple of months

ago. You know, and it's obviously becoming a major burden on the independent pharmacists in particular.

So I'm just wondering where the logical end of this is. The information is going to be great, but I'm hoping it is actionable information that maybe we can do other things to help in particular the independent pharmacies.

DFS DEP. SUPT. OECHSNER: Absolutely agree. I use Four Corners Pharmacy in Delmar -- I hope that's not an advertisement, but they're great. It's an independent pharmacy. And I think it's really important to protect our independent pharmacies.

And so one of the things that we want to do with these new powers is look at some of their pricing practices vis-a-vis the big chain stores as opposed to independent pharmacies, and are they giving those pharmacies a fair shake. So it certainly would be something we'd want to look at.

We'd also want to look at, as I've heard from the Pharmacists Society of the

State of New York, as well as individual pharmacies, examples of what have been described as potentially abusive practices in terms of how they audit after a claim has been paid and how difficult it is, particularly for the independent pharmacies, to fight those audits.

ASSEMBLYMAN RA: And obviously we're dealing with major larger institutions and the independent pharmacists, some maybe own a couple of them, but a lot of them are just local small business owners and pharmacists that are there trying to provide a service to the community and be there to counsel the patients and everything.

So, you know, I think this is a good start in terms of getting some transparency, but hopefully the department and the Legislature can work together to try to address some of those other surrounding issues to this.

DFS DEP. SUPT. OECHSNER: I look forward to it.

ASSEMBLYMAN RA: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Assemblymember Abinanti.

ASSEMBLYMAN ABINANTI: Thank you.

Thank you for joining us today.

I just want to understand what health insurance companies you can regulate. You do the commercial insurance companies?

DFS DEP. SUPT. OECHSNER: Absolutely. So we do --

ASSEMBLYMAN ABINANTI: How are they different from -- what are the other ones that are not commercial?

DFS DEP. SUPT. OECHSNER: So we have any insurer that's participating in the commercial market, basically offering any kind of health insurance product in the commercial market, meaning non-public market -- so like not Medicaid, we don't regulate --

ASSEMBLYMAN ABINANTI: What about like the teachers retirement -- the teachers systems, Empire Blue Cross and those types of things?

DFS DEP. SUPT. OECHSNER: So Empire

Blue Cross is a licensed insurer. They're generally licensed either under Article 42 of the Insurance Law, which is the for-profits, Article 43 of the Insurance Law, which is the not-for-profit commercial insurers, or Article 44 of the Public Health Law, which is the HMOs.

ASSEMBLYMAN ABINANTI: What impact do you have on those that are not licensed by you?

DFS DEP. SUPT. OECHSNER: We do regulate their activity in the commercial market. So if they're offering products that aren't --

ASSEMBLYMAN ABINANTI: Because we often get constituents calling with problems with insurance companies. And I'm not quite sure which ones are yours and which ones are not.

But let me go to the next question, and that is how do you determine what an insurance company has to cover and doesn't have to cover? And where can we see that? Is it online somewhere, or what's --

DFS DEP. SUPT. OECHSNER: So let me tell you the easiest place to look is at our model contract. One of the things that we've been most proud of that we've done at the department is before the Affordable Care Act, just in the small-group market alone, we had over 15,000 different policy forms. And it was really difficult for insurers -- I'm sorry, insureds, consumers -- and providers to figure out what was --

ASSEMBLYMAN ABINANTI: And we can find this where?

DFS DEP. SUPT. OECHSNER: It's on our website.

So we have a model contract, one model contract language that everybody in the individual and small --

ASSEMBLYMAN ABINANTI: All right, the concern I have is for people with disabilities, which is an area that I've been asking everybody about. There's this interplay between Medicaid and private insurers. Which one is primary? Is there a general rule as to which one is primary?

DFS DEP. SUPT. OECHSNER: We have a whole coordination of benefits regulation, and I'm happy to walk you through it offline or you or your staff --

ASSEMBLYMAN ABINANTI: My staff will probably want to do that.

So because -- now the next step is one insurer in particular, and I'm thinking of a case that just happened in my office, basically said Medicaid doesn't require it so we don't require it. Is that a standard way to do it?

DFS DEP. SUPT. OECHSNER: The Medicaid -- I guess I'd want to know what the specifics are, but --

ASSEMBLYMAN ABINANTI: All right. The concern we're dealing with here is I have a person with a disability who is trying to find a particular service and it's not offered in the State of New York. The only place that they could find -- it's the only place that I know of that offers this service -- is a little hospital in Connecticut. There's a crisis situation for

a young man with autism, and he wants to get into this. And I know others with insurance in New York have had it paid for in Connecticut. This insurer says "We don't pay for that service."

Does your office look to see that all services are covered and that every insurance company at least provides one option to people, especially people with disabilities, to be able to get a service somewhere?

DFS DEP. SUPT. OECHSNER: Absolutely. And one of the things that we're really proud of, we worked very closely with the Legislature to pass the surprise out-of-network bill law that protected consumers from surprise out-of-network bills. And in that there's a provision that says for commercial insurers if you do not have an appropriate provider in-network, you need to let the person go out of network at the in-network cost share, and they have a right to an independent review if the health plan is saying no, we think our provider in-network is just fine, you can go to an

independent external appeal to have that --

ASSEMBLYMAN ABINANTI: What they were saying is they have to work out an individual contract with that entity. Is that common in the field, to say, Okay, they're not covered, they're not in our network, they're out of state, we have to work out an individual -- and then they have a standard for what that hospital, which is in this case, you know, governed by Connecticut, and they get Connecticut insurance, they're saying they have to work out a one-time arrangement. I'm not quite sure what the technical term is.

But do we allow that and do we mandate that, or what do we do in that circumstance?

DFS DEP. SUPT. OECHSNER: Well, certainly -- and I'm happy to talk to you more about this offline --

ASSEMBLYMAN ABINANTI: But I'm trying to keep this at a policy level --

DFS DEP. SUPT. OECHSNER: On a policy level, health plans are entitled, under the law, to have networks. The networks have to be adequate, and we can talk about what that

means. And then if they don't have an adequate provider in-network, they have to let you go out of network at the in-network rate, but --

ASSEMBLYMAN ABINANTI: Last question, do they have to give you the name of the provider?

DFS DEP. SUPT. OECHSNER: Yeah, they --

CHAIRWOMAN WEINSTEIN: We're going to move on.

ASSEMBLYMAN ABINANTI: Thank you. Okay, thank you.

CHAIRWOMAN WEINSTEIN: Thank you. You can offline continue this conversation.

Is Assemblyman Byrne here? He left, okay.

Assemblywoman Bichotte.

ASSEMBLYWOMAN BICHOTTE: Hi. Thank you for being here.

So I want to revisit the IVF proposal. So I am a study, okay. Use me. I'm very experienced in terms of using IVF as well as the cycles and so forth. The New York State

insurance plan that state employees have, their premium is very minimal and the coverage is very comprehensive. To the point of Senator Savino, the limit that they give, which is 50,000, does not include the prescription of drugs, the cost of the drugs, so a person, a patient can actually have more than three cycles. They can have maybe up to seven or eight cycles.

And studies will show even with ages in the thirties, the chance of getting pregnant is less than 50 percent. So when we talk about three cycles, three cycles is really not enough. Okay? I know that for an example.

So I want to know the three cycles that was determined, what is the average cost for a cycle in your study? I also want to know if this limit, age -- is there an age limit?

DFS DEP. SUPT. OECHSNER: Mm-hmm.

ASSEMBLYWOMAN BICHOTTE: I know that was a concern in the State of New York, our state employee insurance, we do not have an

age limit. When I was shopping around for insurance, the age limit was 44, in some cases 43, 41. When I was pregnant, I was pregnant at the age of 43. So if I didn't have my insurance, I would have been out of luck. Okay?

Also you mentioned that there are certain health conditions that can be covered under the fertility preservation. Other than cancer, what are those? These large coverage groups that are being considered, are these large coverage groups are under the umbrella of Centers of Excellence? And those are my questions for now.

DFS DEP. SUPT. OECHSNER: Okay. So starting with the first, on the cost per cycle, that's going to be in the report. We did do a huge claims data poll to kind of look at what the actual costs were, so we asked insurers who are providing this coverage to give us examples of it. I don't have that off the top of my head, but it will be in the report.

ASSEMBLYWOMAN BICHOTTE: I can tell

you right now the average cost that I encountered, because I looked at how much everything costs, was anywhere from 13 to 20,000. That's one cycle.

Okay, continue.

DFS DEP. SUPT. OECHSNER: So the age limit, there is not going to be an age limit. That's not the proposal.

ASSEMBLYWOMAN BICHOTTE: Because Janet Jackson had one at 50. Okay.

DFS DEP. SUPT. OECHSNER: And for fertility preservation, the language in the proposal is broad so it's -- it wouldn't just be -- so, you know, other than cancer, it could be any kind of condition that would make the woman infertile. So, you know, it really -- so like the classic example is cancer, you're going in for radiation therapy that is going to -- you know, there's a high likelihood that you will be made infertile as a result of it. So that would qualify. But it could be other conditions.

ASSEMBLYWOMAN BICHOTTE: Okay. Again, I would just encourage that you -- the

Governor and you consider mimicking what the state offers currently to state employees. And when we think about premiums, I mean it's really a small percentage of people across the state or even across the United States that are even using IVF, you know. And so we don't want to think that it's going to increase premiums for all insurance -- those who have insurance. So I want to keep that in mind. Okay? Thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

Assemblyman Ortiz.

ASSEMBLYMAN ORTIZ: Thank you, Madam Chair.

And thank you very much for being here with us. You probably was here when I asked the question to the DOH commissioner about the eating disorders.

DFS DEP. SUPT. OECHSNER: Eating disorders, yes.

ASSEMBLYMAN ORTIZ: I just have a couple of questions and I'm going to follow up my colleague. Because, you know, we do have a big issue with insurance companies to

cover it, what they should and should not cover for behavioral science and kids and people with eating disorders.

I would like to know -- and I know in your statement that you mentioned that, and I quote, that DFS plays a significant role in the New York health insurance market and in supporting and carrying out many of the Governor's initiatives, close quote.

And I'm wondering if eating disorders coverage has been in any way part of any discussion as to expanded and enhanced coverage for folks who are suffering from this mental health illness.

DFS DEP. SUPT. OECHSNER: Absolutely. And without oversharing, you know, eating disorders is something that's affected my family personally. It's something we've definitely talked about. And in the bill to codify the Mental Health Parity and Addiction Equity Act, the federal statute, there's language that fleshes out defining what a mental health condition would be, and it refers to the DSM -- you know, the most

recent version of the DSM, the Diagnostic and Statistical Manual, which is the standard that those in the mental health profession use for determining conditions.

And so all of those would be covered, and that would include eating disorders. And it --

ASSEMBLYMAN ORTIZ: I am very familiarized with the DSM. I was one of the pioneers on creating three eating disorders in New York back in 2005 as a result a young lady in my district suffered from it and the parents had to sell their business, their house, in order to really take the child out of New York because there was not in-service providers. And the only way to do it and to save her life was to take her to New Mexico, and they spent a ton of money.

And as you have your own experience, I do have mine. And I think you and I can share the emotions that psychologically impact on our family. What I would like to see is really if we can sit down together at some point, and even with some of eating

disorder experts to really lay out a plan. I have studied 14 pieces of legislation around the country and also in London, what they're doing, and also in Israel, where they held a consortium on eating disorders, and addressing both components. Because when we talk about eating disorders and we're talking about anorexia, we also have to talk about obesity. They both go hand-in-hand.

And I do -- I do want to share with you -- as you know, I said it, that when you have to take 5,000, $10,000 out of your pocket to help your child because you don't have the services -- or, for instance, you have to -- you've been recommended that your child has to go to a specific psychologist and that psychologist would say to you, I'm sorry, I don't take insurance, it's $200. And you go to a psychiatrist: I'm sorry, we don't take your insurance, or we don't cover it -- there's not coverage under any insurance, we have to pay $400.

That has been my case to help my son with his daughter, my granddaughter. And as

I said, today is the anniversary day that she's been suffering from an eating disorder, and it is a hardship financially, it is a catastrophe, and I hope that we all can work together to make this a priority issue. Because as you know and I know, this is the number-one suicidal -- and we was talking about opioid, we was talking about drug addiction. They have a tendency to go in that direction. And who better than you and I, who have family members, and you work on one side and I work on this side of the aisle, that we can probably work together, not just to save our families but to save many, many, many other families that doesn't have the money to pay for this. I have a bunch of family members in my district, after I came out of the shadows and talked -- and told them about my granddaughter's story, coming to my district office and saying, oh, we have this problem, we've been ashamed to talk about it, and we go for help, it's too expensive.

And we're getting to the point where

if you do have the money to pay, you will be able to get the services. And if you don't have the money, it's like business as usual, you will not get the coverage.

So, you know, I hope that one day we can finally finalize all these issues of insurance companies where we can see New York to be only the New York that has insurance for everybody, that we don't have to worry about between buying food or going to my eating disorder center or to my psychologist or my psychiatrist. Four hundred bucks a week is a lot of money. It's a lot of money. And I pay that for -- on behalf of my granddaughter. Four hundred. That's one psychiatrist and $200.

So I hope we can work together. Thank you very much.

DFS DEP. SUPT. OECHSNER: Well, I look forward to it. And I don't know where Tenuja {ph} is but, you know, you know Tenuja, we'll set something up and talk.

CHAIRWOMAN WEINSTEIN: Thank you. And for a second round, and our final -- for a

second round, but not the final questioner, Assemblyman Garbarino.

ASSEMBLYMAN GARBARINO: I just want to go through -- this budget is putting a lot into PBM licensure, codifying ACA, codifying the marketplace. Each one of those sections, though, we seem to be giving a lot of regulatory power to the superintendent. My concern is past DFS regulations have been seen by some as aggressive, you know, unneeded, unfair, whether it's health-related or not.

So I understand as a Legislature we can't legislate everything, there can't be a statute for everything. But it seems that the Governor is asking for a lot of power here for the superintendent, and I just don't understand why we can't do some of this stuff legislatively, why it all has to be given up to the superintendent for regulations.

DFS DEP. SUPT. OECHSNER: Well, I think -- so there's many provisions in here that we have acted on by regulation that we're asking to be codified to make sure that

they're permanent. And --

ASSEMBLYMAN GARBARINO: I understand that. But it's -- some -- but I would think the Legislature, you know, is here for a reason, you know, to enact the law. Like you said before, you did the -- we did regulations for the contraceptive coverage, I think it was last year. It now is passed -- it was passed this year to be signed into law.

So I don't understand the need or the request for all of this power, this regulatory power, when there's a perfectly good Legislature sitting right here who's able to pass these bills. And I'm not just -- that concerns me. I know you might not have an answer for me, but it's something I wanted to bring up because there is a request for a lot of regulatory power in this budget. And I think that -- it's concerning to me as an Assemblyman. I think it should be concerning to the entire Legislature.

So I just wanted to make that point.

CHAIRWOMAN WEINSTEIN: Thank you.

Now our final questioner, Assemblyman Cahill.

ASSEMBLYMAN CAHILL: All right, Troy, let's really try to do lightning round here.

DFS DEP. SUPT. OECHSNER: Lightning round, I'm ready.

ASSEMBLYMAN CAHILL: I've got six areas. But I'll echo Andrew's concerns and just ask you -- and it's an unfair question, but that never stopped us before. Is it the department's intention to continue the expansionist view that the previous superintendent had, in that if there's a gap in statute, that the superintendent perceives that as a license or authority to fill that void? Or is there going to be a more circumspect approach that would actually follow the Legislature and look for that authority?

Don't answer that.

(Laughter.)

ASSEMBLYMAN CAHILL: I want to confuse everybody here by asking you about PBR.

DFS DEP. SUPT. OECHSNER: Okay.

ASSEMBLYMAN CAHILL: Everybody but you. PBR is principle-based reserves. It was authorized under law last year at the end of session. The department has to issue regulations that will allow insurance companies to change the way that they finance themselves, and therein to calculate their reserves.

Regulations are due. When are those regulations coming out?

DFS DEP. SUPT. OECHSNER: So of course that's not in my swim lane. I'm the health person, not the life insurance --

ASSEMBLYMAN CAHILL: You are also the insurance person here.

(Laughter.)

DFS DEP. SUPT. OECHSNER: So I can't say specifically, but I'll certainly take that back to the life bureau folks.

ASSEMBLYMAN CAHILL: Like to know. And I would just urge the department to do so before the end of June, which I think is what the deadline is, just in case there is a need for cleanup legislation or some gaps are

identified where it's necessary to help implementation.

Second subject, marijuana banking and insurance. I'm not the Banking chair, but I am the Insurance chair, and we can't do either right now. Does the department have a plan to insure and provide a banking system for the marijuana industry?

Don't answer it, get back to me on that.

DFS DEP. SUPT. OECHSNER: Okay.

ASSEMBLYMAN CAHILL: Property and casualty reform. Is there anything on the table for property and casualty reform this year, particularly looking at the ridiculous 20th-century limits that exist for automobile insurance that don't actually cover the costs of care when somebody is injured in a car accident?

DFS DEP. SUPT. OECHSNER: I will definitely take that back to our property folks.

ASSEMBLYMAN CAHILL: Okay. Last thing, Troy, and this goes back into your

swim lane.

When we're talking about developing a single-payer system here in New York, there are many hurdles that we face. Probably in my view, the biggest technical hurdle that we face, we can overcome it in a different way. But rather than using a subterfuge, one of the things we've been proposing at the National Council of Insurance Legislators is to ask Congress to create a waiver process under ERISA, not unlike the waiver process that exists for Medicare and Medicaid, allowing a state to apply to the federal government for -- to have authority where they don't currently have for self-funded plans, in the event that there was a compelling and overriding need.

Would the superintendent consider introducing a similar resolution at the National Association of Insurance Commissioners?

DFS DEP. SUPT. OECHSNER: It's an interesting idea, and I will definitely bring it back to her.

ASSEMBLYMAN CAHILL: Thank you very much, Troy.

CHAIRWOMAN WEINSTEIN: Thank you.

So that is the end of questions. I know there's some people that have asked for some offline discussions and some follow-ups, so we look forward to receiving those --

DFS DEP. SUPT. OECHSNER: Thank you very much.

CHAIRWOMAN WEINSTEIN: -- and some of that will be made part of the record.

So next we have Dennis Rosen, inspector general, the New York State Office of the Medicaid Inspector General.

Feel free to proceed.

INSPECTOR GENERAL ROSEN: All set?

CHAIRWOMAN WEINSTEIN: Yes.

INSPECTOR GENERAL ROSEN: Okay. Good afternoon, everyone. As you have my full testimony before you, I will provide a brief summary and be happy to answer any questions.

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 2018.

OMIG saw an increase in recoveries in 2018. Preliminary numbers indicate recoveries, including audits, third-party liability, and investigations totaled more than $529 million, an increase of more than $27 million over 2017.

OMIG continues to emphasize measures that prevent up-front inappropriate and unnecessary costs to the Medicaid program. These cost-avoidance efforts delivered impactful results for the Medicaid program, as preliminary 2018 data show a savings of more than $1.9 billion. OMIG's auditors, investigators, data analysts and licensed healthcare professionals play a critical role in collaborative law enforcement actions targeting multimillion-dollar fraud schemes, drug diversion cases, and eligibility fraud.

For example, OMIG's participation in the 2018 National Healthcare Fraud Takedown,

led by the federal Medicare Fraud Strike Force, helped uncover more than $163 million in alleged fraud schemes in the greater New York City metropolitan area. Thirteen individuals, including five doctors, a chiropractor, three licensed physical and occupational therapists, and two pharmacy owners, were charged in June of last year in federal court in Brooklyn and Central Islip for their alleged participation in multiple schemes that fraudulently billed the Medicare and Medicaid programs more than $163 million.

As part of the state's multifaceted response to the opioid epidemic, OMIG continues to work closely with law enforcement, healthcare providers, managed care plans and other stakeholders across the state. For example, preliminary data on the agency's Recipient Restriction Program, which limits recipients suspected of overuse or abuse to a single designated healthcare provider and pharmacy, shows more than $89 million in Medicaid costs were avoided in 2018 -- and, even more importantly, many

lives were saved.

OMIG's 2018 preliminary enforcement activity statistics show strong results, with more than 2700 investigations opened, 2400 completed, and close to 900 cases referred to law enforcement and other federal, state and local agencies. OMIG has issued more than 750 Medicaid exclusions in 2018. Once excluded, a provider is prohibited from participating in New York's Medicaid program or any other state's program.

In line with New York State's ongoing transitional fee-for-service Medicaid to a managed care system, OMIG continues to develop and implement new measures and mechanisms to address fraud, waste, and abuse. For example, in 2018 OMIG initiated the Provider Investigation Report. Under the terms of the Medicaid Managed Care Model Contract, managed care organizations are now required to submit one of these reports to OMIG and DOH quarterly. The report provides OMIG and DOH with valuable information,

including but not limited to provider investigative activities performed by MCOs, as well as copies of MCO settlement agreements with network providers.

This information is critical for two reasons. First, substantial MCO recoveries of overpayments may impact capitation rate setting. And secondly, once OMIG is informed of inappropriate provider behavior, it can investigate whether the provider is engaging in such behavior in other MCO networks in which it participates.

OMIG's managed care efforts also include performing various match-based audits and utilizing data mining and analyses to industry potential reviews. For 2018, preliminary data show these efforts resulted in 456 finalized audits with more than $105 million in identified overpayments.

Additionally, last year OMIG established MCO liaisons. An agency investigator is now assigned to each managed care plan in the state. This effort serves to greatly enhance and streamline

communication channels, information sharing, reviews and reporting practices.

OMIG also in 2018 completed visits with every mainstream MCO in the state to discuss program integrity efforts. These two-day on-site meetings provided OMIG with key insights into MCOs' various business processes and procedures. At the same time, MCOs emerged from these sessions much better informed of OMIG's program integrity responsibilities, approaches, and interest in working collaboratively.

To provide OMIG with additional tools to address program integrity issues, the Executive Budget includes authorization to enable OMIG to ensure managed care plans are held accountable for submitting intentionally inaccurate encounter data to DOH. The proposal would also ensure, for the purposes of OMIG activities, any payment made by the state to an MCO or MLTC shall be deemed a payment by Medicaid and would support recoveries of overpayments from network providers. This addresses a longstanding

misconception that once monies are paid by the state to a managed care plan, any payments made by the plan to downstream providers or subcontractors are no longer Medicaid payments and therefore are not subject to oversight or recovery.

OMIG's budget proposal also seeks to hold managed care plans accountable for the program integrity obligations outlined in their contract with the state by conducting program integrity reviews of all plans. This proposal would also require home-care service workers to obtain a free National Provider Identifier. This would enhance the state's ability to confirm an individual aide's services related to submitted Medicaid claims and to also ascertain whether an aide has been cited for quality of care issues. Thus an NPI would provide greater transparency and accountability, which in turn will enhance the quality of care for a vulnerable population of Medicaid beneficiaries.

Finally, reflecting its commitment to education and outreach, last year OMIG

produced numerous program integrity-related webinars and guidance materials and delivered dozens of presentations to and attended on-site meetings with associations, provider groups and stakeholders across the state.

OMIG's compliance, outreach, oversight and enforcement activities, coupled with these outreach and education efforts, serve to increase program integrity and provider accountability, contribute to improved quality of care, and save taxpayers' dollars. Going forward, my office's commitment to its mission and to helping maintain and sustain the state's high-quality healthcare delivery system is unwavering.

Thank you, and I'd be pleased to address any questions you may have.

CHAIRWOMAN WEINSTEIN: Thank you.

We do have a few, so we'll start with Senator Seward.

SENATOR SEWARD: Thank you.

Mr. Rosen, good to see you.

I just wanted to ask in terms of -- your recovery numbers are quite significant

and I wanted to know if -- at the beginning of the year do you have an -- does OMIG have an audit recovery target number that you would be going after, or is every year sort of "we'll see what unfolds"?

INSPECTOR GENERAL ROSEN: We have a general sense, a general target of where we're going. But, you know, we can't, obviously, be constrained by targets, or we're not going to attempt to bring in money improperly just to make a target.

So there's discussion as to where we think we should be, but we always view our targets as very, very flexible, depending on what's uncovered in the course of the year.

SENATOR SEWARD: Have you been going through upgrades in terms of with all the technological advances we've seen and other auditing strategies? Is there anything new in terms of what you're doing at OMIG to produce these results?

INSPECTOR GENERAL ROSEN: We've been very involved in the Governor's Lean Initiative program, so we've taken a lot of

steps to try to be more efficient and streamline our operations. And we've also invested proportionately a tremendous amount, obviously, in data mining and data analyses.

One of the things I just touched on in passing in my testimony just now was that we rely on data matches now, for example, where we can take lists of people who are enrolled in MCOs and who are -- and match that against lists, for example, of people who are out of state now, and the MCO shouldn't be getting a capitation payment. Or perhaps a list of folks who have died six months ago or four months ago. And we can do matches like that now. We didn't always have that capability. But we'll do matches and we'll find that if an MCO wasn't at risk for a period of time, that we will then recover those capitation payments.

Another way we use data is -- just to take a back step and a slight digression, when I first came to the agency, in the first few days one of the calls I had was from a father who his 20-something son had just had

his third emergency room admission. And he had OD'd, as he had done before, because he was getting multiple fills for the same prescription.

And one of the things -- that had a significant impact on me. And, you know, I'm aware of the real world problems, obviously. But this direct one-on-one contact shortly after I came to the agency had a significant impact on me. And one of the things we've done, for example, is to ramp up our Recipient Restriction Program that I referred to a while ago.

And we also have enhanced technology that we use where we will track doctors' prescribing patterns as well as recipients' utilization patterns, and where we see aberrations we will take a closer look, and in some cases refer to law enforcement or go to an MCO and say, You need to put Dennis Rosen on a restrictive recipient program because we find signs of abuse.

But that's another example of how the use of enhanced data mining has enabled us to

do more with what we've got. And we've gotten some very significant results, and we want to keep going in that direction.

SENATOR SEWARD: I appreciate that answer. It all sounds like you're keeping up-to-date in terms of new strategies and technology.

Two quick questions, and I'll try to be brief -- and we both -- so we can cover this. In terms of the language in the proposed budget to extend OMIG's authority in the MCO area, is that based on just the fact that we know there's a lot of Medicaid dollars going to be channeling through the MCOs? Or is there a sense that -- you know, can you point to situations where there has been some fraud and abuse?

INSPECTOR GENERAL ROSEN: We know that at times, for example -- and I want to be clear that what we're talking about in these reviews is using, as the standard, contractual provisions that everybody has agreed to. And those will be published online, and the metrics that we're using will

also be published, so it will be out there and very clear to everybody as to what we're looking at. And there's nothing we'll be looking at that's not in the contracts now that the MCOs are obligated to comply with.

But we have found issues where there's not always compliance. And it's human nature. I in no way wish to go about demonizing people individually or an industry as a whole. I've met some wonderful people in this industry, including people involved with the MCOs.

But businesses are out to make money, and they will make errors in their own favor from time to time. And what we're -- what we want to do is provide disincentives for the MCO to violate the terms of the contract and not comply.

And I'll give you one example. Our visits to the MCOs have been wonderful in terms of educating both sides with respect to what our challenges are, what our issues are, what our expectations are. When our team first went out on the first two or three

visits, there was a lot of apprehension in the industry and you'd see three lawyers sitting there at the table along with the folks from the managed care plan. And then after a while they realized we're not there to ambush anybody, we're there to find out how you do business and how we can help you and how we can tailor what we do to what your issues are and what your problems are. And that's worked out very, very well.

But for example, one of the things we --

CHAIRWOMAN WEINSTEIN: Thank you. Perhaps if you want to follow up at a later time.

INSPECTOR GENERAL ROSEN: Okay. Could I just give a -- just one more sentence?

CHAIRWOMAN WEINSTEIN: We're -- we're going to move on.

INSPECTOR GENERAL ROSEN: Okay, I'm sorry.

CHAIRWOMAN WEINSTEIN: Okay. We are page 1 of five pages of witnesses. So obviously the later --

INSPECTOR GENERAL ROSEN: Okay, I understand.

CHAIRWOMAN WEINSTEIN: There may be opportunity later.

We'll go to Assemblyman Gottfried.

ASSEMBLYMAN GOTTFRIED: Yes, thank you.

And Dennis, as you know, we've talked a lot about your work, and I very much appreciate what you and the office does.

As I understand some of the budget material, it talks about reducing the appropriation for the office but asserts that the number of FTEs would remain the same. Am I reading it right? And how does that work?

INSPECTOR GENERAL ROSEN: Yeah, I think that's something that just hasn't been worked out yet, so I can't tell you precisely how that's going to end up or where the FTEs will be.

I can make a general statement to you that if our budget is cut to a significant degree, based on some of the things I said earlier, the initiatives we've taken through

Lean and through technology, that the agency will certainly continue to be effective in achieving its mission wherever we end up with respect to that.

ASSEMBLYMAN GOTTFRIED: Well, thank you. And speaking of effectiveness, how would you compare the effectiveness nowadays of the Medicaid program, versus the commercial health insurance world, at cracking down and preventing fraud and abuse?

INSPECTOR GENERAL ROSEN: First I have to admit that that's a little beyond my expertise, because my familiarity with the insurance industry commercially, outside of Medicaid, is very limited. You know, I've read, I've talked with people, but I cannot tell you -- I can't give you specifics in terms of measuring the two because the commercial area is something I'm not familiar with.

I do know that for us the challenges are basically twofold. One is the switch to managed care that's been going on and will continue, and also the switch to

value-based payments. In both those areas we've been focusing our resources and our energies. And that's been, for us, very, very challenging, but the flip side of that coin is a very fulfilling experience.

ASSEMBLYMAN GOTTFRIED: Okay. Thank you. That's it.

CHAIRWOMAN WEINSTEIN: Thank you.

Senator Antonacci.

SENATOR ANTONACCI: Thank you, General. I was a county comptroller, and obviously we know that the counties participate not only financially but with some administration in the Medicaid plan. And I worked with many of my colleagues, including Mike Connor, who's the Albany County comptroller and is retiring this year -- great man. And we were always -- I don't want to say frustrated, but thought that there was opportunities for the counties to work together, especially county comptrollers. There's eight of us, primarily in the bigger counties -- Onondaga, Syracuse, Erie County, which is Buffalo, and then

obviously on the Island.

Has the department thought about working with county comptrollers, maybe even treasurers? Could there be some incentives where if there is a recovery -- and it just seems like we're all working from the same pile or pool of information. Wouldn't that be something that would lead to some efficiencies?

INSPECTOR GENERAL ROSEN: I certainly have no issue with having exploratory conversations.

I can tell you that with respect to county efforts, for example, we've been very focused on trying to improve the county demonstration program. We've introduced, for the counties' use, software. We have provider audit documentation software that we use in-house that in the last year, year and a half we've been sharing with the counties. We also have increased the areas under the county demo program where the counties are authorized to do audits under our guidance. For example, assisted living audits and

long-term home health audits have been added to the menu of audits that they may do. We actually did a Lean project -- it was a while ago, about a year ago. But we've been implementing the recommendations of that in our relationships with the counties.

So certainly we're happy to discuss with anybody in the counties any efforts they think that we can make to improve the program. In fact we had a very productive, I think, meeting with the New York State Association of Counties not too long ago, and they'll be getting back to us with some things that we kicked around. So we're happy to attempt to work collaboratively with the counties, certainly.

SENATOR ANTONACCI: Thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

Assemblyman Raia.

ASSEMBLYMAN RAIA: Thank you.

Regarding the NPI numbers, what home health workers would have to apply for a National Provider Number? And would it be limited to home health and personal care

aides, or would it include nurses and therapists as well?

INSPECTOR GENERAL ROSEN: No, it would be the health aides and the personal care aides.

And this is a proposal that's been pushed very, very much by the federal Office for Inspector General. They suggested that home health aides be either enrolled fully in the program or have these identifier numbers.

And as I said in my testimony, if there's a unique identifier number assigned to a home health aide, it's much -- it makes our work much easier to figure out if they did provide services, if they were where they were supposed to be. And even more importantly, it's easier for us or a future employer to ascertain whether or not there have been any allegations of abuse in their background.

I want to emphasize, it's absolutely free. It's set up by CMS online. And you can do it online or you can do a paper application. So it's free, it doesn't cost

anything, so it does not place a burden on either the home care aides or the agencies that they work for.

ASSEMBLYMAN RAIA: One last question --

INSPECTOR GENERAL ROSEN: And just -- sorry, just one other word. It would also help us -- we've been doing these wage parity audits to make sure that workers are getting the minimum wage that they should out of their Medicaid payments. And it would help us with that. It would help us make sure that we know exactly what each worker is getting.

Sorry to interrupt you.

ASSEMBLYMAN RAIA: Now, quite all right. Thank you.

How would the NPI number requirement work with already established systems to vet potential employees providing home care services, including the Home Care Worker registry or a criminal history record, check system, criminal background checks?

INSPECTOR GENERAL ROSEN: It wouldn't

upset anything that's in place now. It's just that there's nothing in place now to deal with the kinds of issues I'm raising.

The Department of Health, for example, has a registry that I'm sure you're familiar with, but that was really set up to make sure that the workers who are registered have the appropriate training and the background to be able to work for an agency in the first place, and it doesn't really focus on the kinds of issues that we're concerned about, such as quality of care for one of the most vulnerable populations.

And also when we see it, you know, people being in two places at the same time or working 30-hour days or being on vacation somewhere while there is billing going on, this will help us with respect to the program integrity side.

ASSEMBLYMAN RAIA: Okay. Thank you very much.

CHAIRWOMAN WEINSTEIN: And back to Senator Seward for a quick question.

SENATOR SEWARD: Right, very quick,

Mr. Rosen.

Obviously, as OMIG, you zero in on provider fraud. I'm wondering have you ever gone after, let's say, recipient fraud and abuse as well? The recoveries may be a little tougher there, but I just wanted to ask that question in terms of on the recipient side because there are, I'm sure, some cases there.

INSPECTOR GENERAL ROSEN: We have a unit specifically dedicated to recipient fraud. And we've worked with prosecutors at all levels, particularly district attorneys, with respect to these kinds of cases. We found, for example, people who provide Medicaid services who we found were collecting Medicaid while they were making substantial amounts of money providing Medicaid services.

So it's certainly an area that we're involved in and I think we're on top of. Of course we are looking for the best use of resources, so we do try to gear our recipient fraud investigations in that direction,

seeing to it that there's really substantial fraud going on.

SENATOR SEWARD: Thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

That's the end of questions for you.

INSPECTOR GENERAL ROSEN: All right. Thank you very much. Sorry to disappoint you, Senator, I heard everybody just fine today. Thank you.

CHAIRWOMAN WEINSTEIN: So we now will begin the public portion of the Health hearing. As was described by Senator Krueger at the beginning, at this hearing the witnesses will each have five minutes. We do have your testimony in advance. It's been circulated to the members, so there's not a need to read it. And in fact it would be much more helpful to have some discussion -- it would help with the discussion for it not to be read.

And at various points we're going to have panels. It's more just to be able to -- it's just with questions and you each, when we call a panel, you each -- unless otherwise

indicated, you'll each have the five minutes allotted to you. And likewise, members will have -- be limited to three minutes to ask questions.

So we have seated at the table, anxious to begin, Bea Grause, R.N., J.D., president of Healthcare Association of New York State, otherwise known as HANYS, and David Rich, executive VP of government affairs, Greater New York Hospital Association -- you can do the acronyms yourself.

(Laughter.)

CHAIRWOMAN WEINSTEIN: Thank you. So Bea, why don't you begin.

MS. GRAUSE: Sure. Good afternoon, Chairmen Krueger, Weinstein, Rivera, and Gottfried and other committee members.

Our written testimony, which we have submitted, does reflect our analysis of the Executive Budget that was submitted on January 15th. But as you know, yesterday Governor Cuomo and Comptroller Tom DiNapoli announced that there's a $2.3 billion revenue

downturn. To say that we are concerned about that is a gross understatement. This federally driven downturn is just the latest in a queue of billion-dollar cuts that are hitting New York's hospitals and health systems.

Not long ago we all worked together to fight hard against the repeal of the Affordable Care Act, but we're currently, down in Washington, very focused on delaying Medicaid DSH cuts that in this budget year, this state fiscal year, would result in $330 million in reductions -- Medicaid DSRIP payment reductions. In the next fiscal year, state fiscal year, it would result in a 70 percent reduction in federal Medicaid DSH payments, for a total of what we had been receiving of $1.8 billion in payments down to $500 million on an annual basis.

That's just one of the cuts. In total, over the next 10 years, New York's hospitals and health systems will receive $40 billion in federal Medicare and Medicaid payment reductions.

So in light of this environment, we urge you to do everything that you can to protect healthcare funding in this budget. Our hospitals have worked hard, from our urban to our rural hospitals, in partnership with the state, to improve the value proposition. And we urge you to reject any cuts that hurt access to care and ask for your continued support and investment in our efforts to improve that value proposition.

I'd like to make a couple of specific points around the budget. The first one is capital. I think as you know there were no continued capital funds, and these dollars -- again, from the large academic medical centers to small rural hospitals, these dollars are precious to allow them to continue to invest in their communities and continue the work in alignment with the Prevention Agenda, DSRIP, and other reform initiatives. And so we ask that you continue that funding.

The second item is the statewide workforce. We thank the Governor and

appreciate the 2 percent increase in Medicaid rates for hospitals and the 1.5 percent for nursing homes. We believe more funding should be included in the final budget to recognize increased labor costs across the state.

In addition, the third item is distressed hospital funding. This funding is critical, again, across the state, urban and rural, for hospitals to keep their doors open, and we ask that you continue this funding. And it was continued in the Governor's budget.

The fourth item, on potential preventable admissions, a $55 million proposed reduction in the Governor's budget. We ask that you reject that. This proposal ignores, again, all of the reform work that is ongoing, again, related to DSRIP and the Prevention Agenda to reduce unnecessary hospital stays and provide appropriate care out in the community.

The fifth item is the $24.5 million reduction in the Executive Budget to cut

Academic Medical Centers for Excellence funding. I think as you well know, New York trains approximately twice as many residents as any other state in the country. This funding is critical for our academic medical centers to help them to train tomorrow's workforce, and we ask that that funding be restored.

And finally, as Senator Rivera mentioned, the nursing home funding, 123 million in state dollars is proposed to be reduced in the Governor's budget. We ask that that funding be restored. These cuts reduce access to needed care. Again, in a community setting, that reduced nursing home access can have an impact on other providers, including hospitals, and more importantly can result in patients not getting the care they need where they need it.

Okay, I'll stop there.

CHAIRWOMAN WEINSTEIN: Thank you.

David Rich.

MR. RICH: Yes, thank you. Thank you very much for having me today. And first of

all, I'd like to thank all of you because you have been so supportive of your hospitals in the past. You know how indispensable they are to your constituents, to your communities -- they're literally saving lives even as we speak. So thank you very much for your support, and we hope we can work with you and gain your support during this budget process as well.

First of all, you know there are challenges in our community. As the Governor pointed out in his budget address, Medicaid has stayed within its cap ever since it was enacted in 2011. He also pointed out that there are other areas of state spending that have not stayed within their caps during that period of time. And we do think -- particularly if there's going to be future belt-tightening, we would think that that should really be taken into account and be given consideration.

Staying within the cap has caused some fiscal distress, though. You know, we haven't had a -- we went 10 years without a

Medicaid rate increase, largely because of that cap. Between 2008 and 2018, while hospital costs were increasing quite substantially, there was no Medicaid rate increase. And as a result, Medicaid rates now only cover 74 percent of the cost of caring for Medicaid patients.

So this has led to distress, and we see it in many different ways. There are 26 hospitals across the state that are on what we refer to as the commissioner of health's watch list for closure. I have some maps in our written testimony to show you exactly who they are. But another significant number of hospitals are not technically on the watch list but nonetheless desperately need help.

And just as Medicaid does not cover the cost of care, Medicare underpays providers as well. In New York State, Medicare covers only 80 percent of the cost of caring for its beneficiaries. Unfortunately, as Bea said, some in Washington are trying to make this fragile

situation even worse.

The Trump administration continues to attack the ACA. They've put out regs every year that drastically cut payments for outpatient services and for safety net institutions. We're facing the Medicaid DSH cuts that Bea mentioned on October 1st, which would take out $600 million from safety net providers in the next federal fiscal year. And even while this is happening, for-profit insurance companies are denying payments to hospitals at record rates. So all of this creates a huge amount of uncertainty.

For these reasons, we are pleased that the Governor's budget actually allows, for the first time, Medicaid spending in excess of the global cap. The budget allows for an increase of 3.6 percent. That accommodates the 2 percent increase in hospital Medicaid rates that the state provided in November, made possible by the $1 billion Transformation Fund enacted in last year's budget. These increases are the first in a decade, and we are grateful to the Governor

and to you for your support of the Transformation Fund last year. The increases enabled us to continue to provide high-quality care, pay good salaries, and provide excellent benefits to our employees.

In addition, we strongly support capital continuing in the budget. We'd obviously like more, as Bea said, and also the funding for financially distressed and safety net hospitals.

But having said this, there are provisions in the Executive Budget that cause us significant concern. Given the fragile financial state of our hospitals, we cannot afford to suffer any cuts in state funding that would undermine the progress that we've made. For this reason, the news yesterday about a $2.3 billion revenue shortfall is extremely alarming and could spell healthcare disaster for many of our communities if it translates into major hospital cuts.

Provisions already in the budget include, as Bea said, cuts for so-called avoidable hospital admissions -- whatever

they are -- cuts in payments to providers for caring for low-income Medicare beneficiaries, the crossover cut some of you have mentioned, cuts to school-based health centers, and cuts to health homes and, as Bea mentioned, cuts to academic medical centers. So we would urge you to reject all of those.

One last item I'd like to mention that is not in the budget, but some of you have referenced -- it was included in the Governor's briefing book, but not actually a statutory provision -- was a study on staffing. The Executive does not propose legislation to force hospitals to hire more nurses, which we are very thankful for in the midst of a nursing shortage in many areas of our state. But he does call for a DOH study on healthcare staffing. While we remain steadfastly opposed to any legislation to mandate specific staffing levels in hospitals, we look forward to working with DOH so that future discussions on this are based on facts and not on unproven anecdotes.

In November the voters of

Massachusetts -- not the legislature, but the voters of Massachusetts -- roundly rejected by a vote of 70 percent to 30 percent a ballot initiative that mirrors our bill that's been introduced in our State Legislature for so many years. And there's no reason to believe that New York voters wouldn't do the same if given the chance.

Finally, I would like to take a moment to publicly thank our partners, 1199 SEIU, who we worked so closely with to expand insurance and to improve our healthcare system.

And with that, I will take any questions that you have, and we have a lot more detail in our written testimony.

Thank you.

CHAIRWOMAN KRUEGER: Thank you very much. Appreciate you both being here today.

Our first questioner -- oh, we were joined by Senator Metzger when I just wasn't looking. Hello.

Do you have any questions? Just double-checking. Well, then, I have just one

question. Thank you.

I don't know if you heard earlier when I asked the question of the commissioner of health from the study that came out today --

MR. RICH: Right.

CHAIRWOMAN KRUEGER: -- about hospital costs dramatically increasing, but it's not physician costs. So can you help me understand what the story is here?

MS. GRAUSE: Sure. I think we can both address that. I think the short answer to that question is no margin, no mission. And all of New York's hospitals are not-for-profit.

That article is actually a national article, and the article focused on market share and increasing market share as a way to increase revenue.

And I think that certainly there is not one reason why hospital prices are increasing -- not just one reason. I think increasing prices to -- as a result of market share is one strategic way to secure the future. Again, building a budget is not just

a one-year exercise. The strategic planning encompasses five, even 10 years, for larger health systems.

But also increasing prices is a result of government underpayments, and it really -- hospitals, like the economy, are -- is very local. And so I think the payer mix of a hospital, depending on the number of Medicaid, uninsured, and commercial patients that receive care in that community, really depend and drive the change in hospital prices.

And again, the prices may vary, but the bottom line for the hospital is to have a margin at the end of the day. And so the individual prices are really just the charges, it's not what any individual winds up paying. So that's just as short as I can make it.

But Dave, I don't know if you have anything.

MR. RICH: Well, I would just argue that the study is not relevant to New York State.

MS. GRAUSE: Right.

MR. RICH: Because they did not include data from most of our insurers. They didn't include Empire, Emblem, Excellus, CDPHP, MVP.

It says that some of the reason for increasing hospital prices across the country is because monopolies have formed in certain areas. We don't have large for-profit hospital chains in this state. I think we have probably the most competitive marketplace for hospitals, particularly in the downstate region, but also in Buffalo and some of the upstate cities. We have huge systems competing with each other in your district, Senator Krueger. As you know, they compete quite strongly with each other. And so I really think that it's not a study that reflects what's going on in New York State.

And I also just should point out that, you know, the data that they used from one of the insurers -- one of the insurers they did use data from which we do have in New York State is UnitedHealthcare. They are making

money hand over fist. They have an $80 billion market capitalization as of this morning. So I think if we're going to look at cost increases, we should also obviously be looking at these insurers and how they're making so much money.

The study also didn't take into account hospital cost increases. So for instance, pharmaceutical costs in two of the years they studied, 2007 to 2014, our pharmaceutical costs for hospitals went up 38 percent in just two years.

MS. GRAUSE: All big points.

MR. RICH: So it's important to look at all of that.

CHAIRWOMAN KRUEGER: Thank you very much.

MR. RICH: Sure.

CHAIRWOMAN KRUEGER: Assembly?

CHAIRWOMAN WEINSTEIN: Assemblyman Gottfried.

ASSEMBLYMAN GOTTFRIED: Yeah. The proposed cut in funding for major Academic Centers of Excellence -- I mean, there are a

lot of items in state hospital funding that go to academic medical centers. The numbers I've always seen are significantly bigger than $24.5 million. What is this particular item?

MR. RICH: So this has an historical aspect to it. You might remember about 10 years ago there were a whole bunch of changes made -- it was under the Paterson administration -- in different funding streams for hospitals. We used to have a big GME pool, as you will recall, because you were there at its creation --

ASSEMBLYMEMBER GOTTFRIED: Yeah.

MR. RICH: -- under HCRA, and it was about -- I believe about $400 million. In that year it was eliminated and transferred and made into other payments to other types of institutions.

At the same time there were large inpatient cuts, there was rebasing of Medicaid, there were all these moving parts. And there were a few academic medical centers who really came out very big losers in that

process. And so in trying to make sure that they were not as hurt by that, that $24 million pool was created from what had been a $400 million pool.

Those academic medical centers that do benefit from that pool, as Bea said, they provide extremely high-end care. The DRGs that their patients fit into, meaning, you know, they have much more complicated patients than others -- and so we would argue that that should not be the place that the Legislature's looking for to save money.

ASSEMBLYMAN GOTTFRIED: Okay. Thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Any Senate? No, we have no Senate.

CHAIRWOMAN WEINSTEIN: So then we'll go to Assemblyman Cahill.

ASSEMBLYMAN CAHILL: Thank you, Madam Chair.

Hi, folks, and welcome.

When people of my age group think about healthcare, we think about hospitals.

I don't know that younger people are of the same mind; healthcare looks very different to them. But I recall, from the time I started paying attention to hospitals, it seems like you were always in the emergency room. Like you were always precariously balanced with your finances, there were always issues about staffing, there were questions about whether reimbursement was going to do indelible harm to you. And there were concerns about competition from the private sector, the for-profit sector coming in and taking away your profit centers.

And you mentioned before the hospitals that are at risk today, even by some standard that may or may not be exhaustive.

MS. GRAUSE: Sure.

ASSEMBLYMAN CAHILL: When is it going to be okay?

MS. GRAUSE: Not anytime soon, I don't think. You know, I think there are a lot of -- you referenced a lot of moving pieces. And Dave and I both mentioned the changes at the federal level, largely driven by cuts in

the Affordable Care Act. So there just are a lot of moving pieces. I think that how hospitals are paid is one factor, and how care is delivered is another. The changing needs of the 19 million New Yorkers who we serve is another factor, and the change of -- actually changing technology and how care is delivered. So there's just a lot of different moving pieces that are impacting the hospitals.

You know, again, all of our hospitals are not-for-profit and work to serve the unique needs of their community. And those needs are constantly changing, so our hospitals are changing in sync, trying to stay in sync with that, to meet their needs using the latest in technology, which is extremely expensive, and making sure that they are retaining the best and the brightest in terms of physicians and nurses, and incurring those costs.

ASSEMBLYMAN CAHILL: I am a cosponsor and have been a cosponsor of Assemblymember Gottfried's New York health bill that would

call for a takeover of health insurance, essentially, by the State of New York. My biggest concern -- and I'm going to run out of time in a few seconds -- my biggest concern in the whole equation is that we are taking on the financial responsibility for what appears to me, from my own experience, to be something that's unfixable.

Year after year after year, hospitals and others in the healthcare professions come to us and they say, Don't give us less. Don't give us less. And invariably we give more. But we still seem to be stuck in that same place where everybody is uncertain about the future of what I think is the keystone to healthcare, so --

MS. GRAUSE: Yes, I would say that we have been doing more with less. So I would respectfully disagree with you on that.

I also would say, and I would agree with you in that, as we talked the other day, that the most important question in our view is not whether or not to publicly finance healthcare in the State of New York. It's

what are we financing. And I think that is a very important question to ask.

ASSEMBLYMAN CAHILL: Thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

Assemblyman Raia.

ASSEMBLYMAN RAIA: Thank you.

I would agree with you. We have a habit of giving with one hand and taking away with the other hand, so essentially you're never in the positive when it comes to monies that we give you.

That being said, the Governor is calling to study safe staffing ratios and single payer healthcare. I have no reason to believe that we are not going to vote on those bills as standalone one-house bills regardless of what the Governor wants to do, and study it, which I think is a good thing.

So that being said, what are your biggest concerns with both of them, and what do you feel the potential impact on hospitals will be?

MR. RICH: Well, I think on the issue -- and you've just laid it out very

nicely in terms of government financing of healthcare. And Assembly Cahill asked the question about when are the finances going to get better. The hospitals that really do have the worst finances in the state are ones that rely the most on the public payers of Medicaid and Medicare. Upstate it tends to be Medicare, very high Medicare. Downstate it tends to be very high Medicaid and Medicare. And so that's our experience.

And, you know, I've talked to Assemblyman Gottfried and Senator Rivera about this in the past, and they obviously do not plan for the New York Health Act to look like this. But in trying to convince our members, whose history with public payers -- Medicaid now covering 74 percent of cost, as I said before, Medicare paying 80 percent of cost -- it's not a pretty history. And so that's why we do have concerns, a lot of concerns, about the single payer bill.

Nurse staffing, I mentioned some of our concerns earlier. I don't know if you'd like to --

MS. GRAUSE: I think David said it well and covered the New York Health Act concerns. But I think the study that Commissioner Zucker mentioned, we think is a good approach.

There are many -- you know, there are many important and different ways to deliver safe care, and the delivery of safe care varies tremendously. I'm a registered nurse myself, I've worked many years in the emergency room and ICU. And, for example, in a large urban facility you may have, in addition to registered nurses and nurse's aides, you may have phlebotomy teams, you may have transport teams, you may have heavy lift teams. In a rural area you would have none of those.

And then I guess the only other thing I would say -- so the team of caregivers is critically important, and I think Commissioner Zucker appropriately mentioned that earlier this morning. I think in addition, as we are talking about how to change how healthcare is paid for and how

healthcare is delivered, that's in a constant state of innovation. And I believe that government-mandated ratios superimposed on that would absolutely halt innovation in that area and I think, in our opinion, therefore halt our ability to improve the value proposition over time.

ASSEMBLYMAN RAIA: Thank you very much.

CHAIRWOMAN KRUEGER: Thank you. I think that concludes our questions for you both. Thank you very much for being with us today.

MR. RICH: Thank you very much.

CHAIRWOMAN KRUEGER: And we have not hit the second page of a five-page list of testifiers. Sorry.

So for those of you diehards who are here with us, the Community Health Care Association of New York State, Rose Duhan. And then for people to get ready to head farther south -- so, I'm sorry, so New York State Nurses Association soon after, then Medical Society of the State of New York soon

after.

Good afternoon. How are you? And welcome to be here. You have your five minutes to testify, so we'll urge people not to try to read their testimony because you'll only get through two pages and then you'll be sorry.

MS. DUHAN: Good afternoon. Is this on? Good afternoon. My name is Rose Duhan. I'm the CEO of CHCANYS, the Community Health Care Association of New York State. And thank you for the opportunity to provide testimony this afternoon regarding the Governor's Executive Budget proposal.

CHCANYS represents 72 community health centers that operate nearly 800 sites in every borough of New York City and in every corner of the state, from Riverhead to Champlain to Chautauqua. Community health centers are nonprofit, patient-governed clinics located in medically underserved areas. They provide high-quality, cost-effective primary care, including behavioral and dental health services, in

communities where there is no -- maybe no other access to these services. They provide these services to everyone who comes to them regardless of their insurance status, their immigration status, or their ability to pay.

Community health centers provide primary care to 2.3 million patients annually. That's one out of every nine New Yorkers. Nearly 90 percent of patients are poor or very poor; 60 percent rely on Medicaid. More than one-fourth are best served in a language other than English. Two-thirds identify as black and/or Hispanic, and 16 percent are uninsured. That's three times the statewide average that we've discussed.

Community health centers do not collect information on immigration status, but as they make all efforts to enroll everyone who is eligible in Medicaid, we gauge that uninsured patients at community health centers are not eligible for coverage due to their immigration status. As such, CHCANYS is extremely concerned about the

detrimental effect the Trump administration's proposed changes to public charge determination will have on New York State's immigrant population and communities. As I know, many of you also are, and that you have also provided that feedback to the federal government.

As you may know, the rule proposes to expand the list of government programs to include Medicaid when evaluating whether an individual is likely to become a public charge dependent on government subsidies and would therefore be ineligible to be granted legal admission to the country or permanent residency status. While it's still only a proposal, the change in policy is already having a chilling effect on people who are choosing not to enroll in government programs for which they are now eligible, for fear of repercussions for themselves, their family members, and their loved ones. And I know many of you are also hearing this from your constituents.

Our member community health centers

report that people are already declining to renew Medicaid coverage and in fact are delaying seeking critical health care services such as early prenatal care, and as you know, that can have important health consequences. A national study found that as many as 95,000 patients just at New York's community health centers could lose Medicaid coverage. Our written testimony includes further details on the harm this proposed rule is already causing that we're seeing at our health centers, and I can provide copies of the federal study that I referenced.

CHCANYS appreciates that the Executive has included 54.5 million in the proposed budget for safety-net funding specific to community-based providers, as it helps cover the cost of caring for the uninsured at health centers, and asks that these funds be increased to meet the growing need.

To address federal threats to immigrant coverage and ensure ongoing access to comprehensive primary care services for all New Yorkers, regardless of immigration

status, CHCANYS asks the Legislature to increase the diagnostic and treatment center safety-net pool by $20 million.

Since this funding is eligible for a federal match, adding 20 million in state dollars results in a 40 million net increase to the pool.

I know you've all had a long day, and I'm hoping to get some of those points that Senator Krueger referenced, so I refer you to our written testimony for details about our other positions. I'm happy to answer any questions you may have.

CHAIRWOMAN KRUEGER: Thank you. I'm glad I've trained everyone.

Any questions on the Senate side? No?

Assembly.

CHAIRWOMAN WEINSTEIN: Anybody? Nope.

Thank you.

CHAIRWOMAN KRUEGER: Thank you very much for your testimony today.

MS. DUHAN: Thank you.

CHAIRWOMAN KRUEGER: Our next testifier is New York State Nurses

Association --

SENATOR RIVERA: What about Auster? Right there.

CHAIRWOMAN KRUEGER: Oh, I'm sorry. Excuse me. Oh, I'm sorry, you're the Medical Society?

MR. AUSTER: I am. I am.

CHAIRWOMAN KRUEGER: Okay. So actually the Nurses Association was scheduled to go before you.

MR. AUSTER: Oh. Well, they can --

CHAIRWOMAN KRUEGER: So is the Nurses Association here?

Just stay.

CHAIRWOMAN WEINSTEIN: Stay there, Moe.

CHAIRWOMAN KRUEGER: Stay there and be comfortable.

MR. AUSTER: I want to be ready to go.

CHAIRWOMAN KRUEGER: Thank you. You were ready for us. Thank you. So we'll let the Nurses Association -- we'll stay in order -- go; Jill Furillo, executive director. And then afterwards, the New York

State Medical Society.

MS. FURILLO: Good afternoon. I'm Jill Furillo. I'm the executive director of the New York State Nurses Association, the largest union representing registered nurses in New York State, with more than 42,000 members.

We strongly support legislation and regulations that allow nurses and other direct-care healthcare workers to provide care for our patients and communities in compliance with professional standards with guaranteed safe staffing ratios. To that end, we welcome the Governor's proposal to direct the Department of Health to conduct a study of ways to implement, as it says in his budget items, staffing enhancements to improve patient safety and the quality of care in hospitals and nursing homes.

The proposal recognizes the inherent authority of DOH to regulate hospitals and nursing homes to ensure patient safety. It further directs the DOH to evaluate the need for staffing enhancements to improve patient

care, and the impact of improved or enhanced staffing regulations on patient safety and the quality of care. So what we're looking at everywhere in the State of New York are improvements.

NYSNA and a range of other labor and community advocates for safe and high-quality patient care strongly support the expansion of existing mandatory staffing standards, legislated and regulated mandatory staffing standards that exist in the State of New York. We believe that they need to ensure that hospital and nursing home patients have enough registered nurses, licensed practical nurses, nurse's aides, patient care technicians, and other direct patient care workers on their interdisciplinary care team to receive safe and proper care.

We believe that the best way to ensure that patients get the care they deserve is to establish safe staffing ratios of caregivers to patients, including the classifications of healthcare workers that we've mentioned.

This point is supported by rigorous academic research and actual experiences of New York State and other jurisdictions that have successfully implemented minimum staffing ratios.

In fact, New York hospitals have used staffing ratios to plan patient care, and in some specialized units there are legislated minimum staff-to-patient ratios in effect, and I can name those units. Those units are CCU, burn units, liver transplant, in the ER, and PACU.

So the problem that we have here in the State of New York is we already do have legislated and mandated staffing ratios, but what's happened over the years is that the acuity of our patients in hospitals has gotten much higher and more severe, and so what we're finding is you find patients who are acutely ill, requiring intensive care, who are no longer seen in those units but are actually going out to other units in the hospital, such as the medical surgical units and the emergency room, to our telemetry

units, step-down units -- and what the problem is, is that we don't have legislated mandated staffing ratios in those units. And that's not fair, and it's not right for the patients.

So it's disingenuous in some ways for spokespersons for the hospital industry to say that they don't agree with these ratios, because they've lived with these ratios for many years in these units and have never spoken against that. So we find that to be somewhat disingenuous.

The Leapfrog report that was issued this year and last year and every year has given New York dismal ratings. As a matter of fact, if you open the report -- I have it here, right here -- this report opens to the first page, Albany Medical Center, right nearby. A C, they get a C. Now, this is measured against all the hospitals in the United States. And what we're looking at, for every one who's here presently, if you get ill or you get sick, do you want to go to a hospital that gets a C, or would you like

to go to a hospital that gets an A? I would say that you would probably want to be in a hospital that gets an A.

The disparities in the quality of care are unconscionable, and the state should address this problem by expanding current laws and regulations to set safe staffing ratios and standards to cover all units in hospitals and nursing facilities. Safe staffing minimum standards is fiscally sound and will save money for hospitals and nursing facilities. We're talking about budget issues, we're talking about the monies that we are receiving for our facilities. Every study has shown when you implement these standards, it saves money to the healthcare system. So we think that any study that's done in this state needs to look at the offset costs of implementing this sound policy.

A well-established body of research shows that the more patients assigned to a nurse and other direct-care staff, the worse the quality of care that is received by the

patients. Higher mortality rates, poorer patient health outcomes, increased incidents of comorbidities, complications, and length of stay. Longer recovery times and length of stay unreimbursed --

CHAIRWOMAN KRUEGER: Thank you very much. I'm going to have to cut you off there.

MS. FURILLO: I had other items in my testimony that has been submitted, written testimony. And I want to point out especially our position regarding the ICP pool funding and the fact that the study has not been issued and that we want to see changes in what we've seen in the budget on that issue.

CHAIRWOMAN KRUEGER: Thank you very much for your testimony. I'm sorry that we couldn't let you continue.

Next we do have Morris Auster, Medical Society of New York State, vice president, chief legislative counsel.

MR. AUSTER: Good afternoon. Thank you very much. My name is Moe Auster. I'm

the senior VP for the over 20,000 physician members who comprise the Medical Society of the State of New York. We represent physicians of every specialty, every region, and of every type of practice construct from solo practice, small practice, large group, to entire hospital medical staffs.

Our written testimony details a number of different issues we see in the state budget, both positive and negative. It also lists off a lot of the various hassle factors that physicians are facing right now and which are leading to an increasing number of physicians reporting symptoms of burnout. These contributing factors include dysfunctional electronic medical record systems, it includes increasing prior authorizations that they're facing with insurance companies and public payers, and also the overwhelming costs, overwhelming overhead practice costs as well.

With that in mind, before we note our items of concern, we do think it's important to highlight some of the positive aspects

that we see in the Governor's budget, which include his proposal to increase the tobacco and e-cigarette purchase age from 18 to 21, which has long been a position of the Medical Society; providing stronger regulation and oversight of pharmaceutical benefit managers -- and on that front I'd like to thank Assemblyman Cahill and Assemblyman Gottfried for their statements. I know Assemblyman Cahill mentioned it this morning as well, and Assemblyman Gottfried I know had referenced it in hearings last fall regarding the proposed acquisition of Aetna by CVS Caremark and our concern about the increasing consolidation and their concern about -- reference about the increasing consolidation in the healthcare industry.

We support proposals in the Governor's budget that would help bump up in strength in New York's Mental Health Parity Law provisions that would eliminate prior authorization for prescribing buprenorphone, which we think is one avenue to helping to address addiction in New York State, and also

we support the extension of New York's Excess Medical Malpractice Insurance Program and the creation of a maternal mortality committee with important confidentiality protections.

I also want to thank Assemblyman Raia for referencing before the concerns that many physicians continue to have about Health Republic and the fact that many health care practitioners -- physicians, hospitals, other healthcare practitioners -- have not really seen anything that's arisen out of that, so we're welcoming efforts to try and address that outstanding gap.

With regard to the areas of concern, we appreciate that in the budget the Health Department is proposing ways in which to bump up New York's very low Medicaid payment for primary care. Right now, actually our Medicaid and Medicare ratio is one of the lowest in the country, I think it's 56 percent. In that regard we have significant concerns that came up earlier today with proposals that would significantly cut the deductible crossover payments to

physicians who treat dual-eligible patients. We know there was a lot of focus earlier on the ambulance cuts, but there's also a cut that would significantly impact upon physicians. Our estimate is that it would basically be an $80 per-physician cut. So if you're a practice that treats a lot of dual-eligible patients, which is probably many physicians across the state -- ophthalmology, urology, cardiology, internal medicine -- if that includes 500 patients who are dual-eligible, that's a $40,000 cut to your practice.

That's outrageous. It's unfair to be balancing the budget on the backs of physicians providing care to patients. And we're concerned that it's actually going to drive patients into more costly institutional settings.

We also are concerned with the continuing -- with another proposal that's been year after year that would increase prior authorization burdens by eliminating the prescriber prevails protections for

specific -- for prescriptions in Medicaid and also for certain categories of prescriptions in Medicaid managed care. We thank the Legislature for their efforts year after year in rejecting that cut, and we hope that you will do it again.

Also we continue to have concerns, as many other groups have expressed as well, with proposals to legalize recreational marijuana use. We know that there are many other groups out there that also share our concern -- from the sheriffs, to county health officials, to parent-teacher associations, to other mental health associations which have expressed concerns.

We do support the idea of decriminalizing marijuana possession, and we'd be very interested in sort of an elongated conversation about how best we can do that. But we are concerned, based upon some data in other states -- even though we know there's some mixed data on it, but we are concerned about some data in other states about an increase in drugged-driving arrests

as well as some cases where the rates of teen use have gone up.

We also have concerns with the workers' compensation portion. It's not in the health budget, but it's in the general government budget. We think that the state has done some efforts to address workers' compensation hassles faced by physicians, but needs to be doing more, and given the fact that up until last year we had -- physicians have not had any increase in workers' compensation in over 20 years. That's why we think there's a reason why there's such a -- there's some shortages in workers' compensation.

And again, on the access, we would welcome participation on the commission to expand access to the uninsured if one were to be enacted as part of the budget.

And with that, I'll take any questions.

CHAIRWOMAN KRUEGER: Thank you very much.

Senator Diane Savino.

SENATOR SAVINO: Thank you. Good to see you, Moe.

So I just want to focus a bit on the marijuana question. I understand the Medical Society has some concerns about the implementation of an adult-use model and particularly around how it could affect people -- the issue of smoking. But we have had in place for the past almost five years now a medical program in the State of New York. We are now servicing almost 90,000 patients, many of whom are sharing with those of us who were proponents of medical marijuana that it has changed their lives. A reduction in opioid usage, the ability to manage chronic pain symptoms, posttraumatic stress disorder has been a game changer for a lot of people.

So I'm curious that you guys didn't mention anything, because your Medical Society has not been particularly supportive of medical marijuana. You're not as hostile to it as you were once, but your testimony doesn't talk at all about the benefits of

medical use.

And while there may be limited data on states that have moved to adult use -- I think we're looking at 10 now that are up and running -- we have 24, 25 states that have long-serving medical programs. So is it possible the Medical Society is moving beyond their initial objection to medical marijuana? What are we seeing from doctors?

MR. AUSTER: That's a fair question, Senator.

I think when the program got adopted, the medical program got adopted several years ago, I think we did not strongly object at the time because I think we believed that the list of conditions that were set forth -- there was some science base behind the conditions. Whether you're talking about ALS, whether you're talking about cancer, whether you're talking about epilepsy, wasting disease, that there was some science.

What we get concerned about, what our physicians have been concerned about, is evolving away from situations where you have

clear studies and rigorously approved studies suggesting that this is a medication to treat a particular condition to those that maybe the evidence is a little bit more anecdotal. And again, at the end of the day, our members are scientists.

SENATOR SAVINO: True.

MR. AUSTER: And they base their perspectives on the extent to which there are scientifically proven methods for treating a particular condition. So I think that's kind of how they approach it --

SENATOR SAVINO: Fair enough.

MR. AUSTER: -- and I think that in -- just in going forward, I think we'd like to see that type of scientific continued analysis if we're going to move to adult recreational use.

SENATOR SAVINO: But just remember, many of your doctors, your members who are scientists, also prescribed medications for off-label purposes all the time because they see the benefit and how it affects their patients. So I would just hope that they

would be as willing to do the same with medical marijuana.

One question -- we have had a problem with recruiting physicians. We do better with nurse practitioners and physician's assistants; it could be the ideology that they have. But in the past we have asked for you all to help us with outreach to doctors. I would hope that you guys would consider that, because again, four and half, almost five years in, we're seeing how it has changed the lives of thousands of New Yorkers every day.

MR. AUSTER: And we'd be happy to help. Certainly we've already done education outreach, we promoted to our -- about how physicians actually can become approved medical marijuana prac -- well, not practitioners, but they can be certified to certify --

SENATOR SAVINO: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

MR. AUSTER: -- patients for that.

CHAIRWOMAN KRUEGER: Thank you.

Assembly.

CHAIRWOMAN WEINSTEIN: Assemblyman Cahill.

ASSEMBLYMAN CAHILL: Thank you.

Hello, Moe, how are you?

MR. AUSTER: Good. How are you?

ASSEMBLYMAN CAHILL: Good, good.

I wanted to touch on two things, but I wanted to start with the very careful way that Senator Savino addressed your comments about recreational marijuana.

I don't know any colleague who is supporting the legalization of recreational marijuana. And if you continue to use the word as you did in your testimony and five times in your written testimony, you may indeed be encouraging young people to think that's exactly what we're doing and therefore increase the likelihood of their usage.

So I would ask that you go back and reconsider the use of that term. Less than 10 percent of adults surveyed over 50 said that's what they would use legalized marijuana for. That means 92 percent --

actually, it was 8 percent -- 92 percent said they would use it for other purposes. That's people over 50. The number for people of all ages is something approaching 70 percent.

Recreational use of marijuana is incidental to the legalization of marijuana, and the overemphasis on it I think sends the wrong signal. So I would just ask you to be as careful in your language, as Senator Savino was when she talked about adult-use marijuana, which is very different. And that's what we are indeed considering, not just recreational.

I wanted to ask you to give me more details about your organization's support for the Governor's proposal for regulation of PBM. Can you tell me what about the Governor's proposal you like, and if there's anything about it you don't like, what would you like to see changed?

MR. AUSTER: I think it's a theoretical support for the idea of having an entity which impacts -- which ultimately has the impact of affecting which drugs are going

to be on a formulary and the rules by which a doctor is going to prescribe a medication to patient, to have greater transparency of the basis for the decisions that are being made.

ASSEMBLYMAN CAHILL: Does it concern you at all that before the ink is dry on the Governor's proposal, the largest -- or one of the top PBMs in the country has already indicated that they'll have no objection to it?

MR. AUSTER: I think that they -- I think that that was certainly -- we know those were discussions that came up in the fall among a couple of different PBMs, in the fall, that they had raised -- that they would not object to it.

I think having some element of sunshine there is better than having no element of sunshine. I will defer to others about the exact precision of it, but I think it's -- I think certainly this proposal is a good start towards at least having some better basis for why formularies are developed the way they are.

ASSEMBLYMAN CAHILL: Did you or your organization participate in the negotiations as apparently -- or perhaps CVS and Caremark did -- leading to the Governor's proposal for PBM regulation?

MR. AUSTER: No, we did not have any discussion --

ASSEMBLYMAN CAHILL: You did not. Okay.

MR. AUSTER: -- about that.

ASSEMBLYMAN CAHILL: Okay. Thanks.

MR. AUSTER: Yeah.

CHAIRWOMAN KRUEGER: Thank you.

Assembly, continue.

CHAIRWOMAN WEINSTEIN: Assemblyman Raia.

ASSEMBLYMAN RAIA: Thank you.

Hello, Moe.

What is the status of staffing when it comes to doctors across New York State? Are we experiencing shortages in certain fields? Are there enough doctors to go around to provide the services that are needed, as far as you know?

MR. AUSTER: I think you have various regions of the state where you're facing a significant shortage. You also have areas where the physician population is aging and where you do not have as many physicians in a particular area as you may once have had, which has then forced in some cases -- I think particularly where you've seen it, and I will quote a HANYS study -- where I think you actually had ERs across upstate New York which did not have adequate on-site specialty call. They had be to be transferred to other hospital centers when that type of specialty was not available when someone came to the emergency room.

ASSEMBLYMAN RAIA: Do you see part of the problem -- I mean, I have three relatives that are physicians that have all moved out of New York State, primarily because of the cost of insurance and just the cost of doing business and overregulations.

One of my concerns is should we move to a single-payer type of system, that you're going to be dealing with rationing of

medicine and artificial setting of rates. Are physicians concerned that they may see a reduction in their income as a result of switching to single-payer?

MR. AUSTER: You know, it's -- the Medical Society of the State of New York has had a longstanding position in support of a multipayer system and not a single-payer system.

That being said, we have a lot of members within the -- who are members of the Medical Society, a lot of primary -- and not just primary care physicians, but other physicians as well, who are supportive of the single-payer system. That has certainly caused us to look very carefully at the proposal.

We still maintain a position of significant concern with that proposal. We've had some discussions with the chairman of the Health Committee -- the chairmen of the various Health Committees about concerns we have with the bill. I know again, to quote a comment I think that I heard Bea

Grause say at the Empire Institute event a week ago: "The devil's in the details."

And we know where there are concerns we've raised about prior authorization, about how folks can appeal, I certainly think that there would be -- the cut that we mentioned, the proposed cut that we mentioned before, about the Medicaid crossover cut, is an example of some -- I think is an Exhibit A for some physicians who believe that if you have a single-payer system you could have that type of, Hey, you're going to cut payments in order to balance the budget.

So again, I think we'll still continue to evaluate it. We still have a longstanding position of significant concern with that type of system. But I think there is -- you know, I think it's -- you know, at some point there's probably going to be some type of conversation that's going to take place, and that's why, if there is, we want to make sure we have meaningful physician representation at that table.

ASSEMBLYMAN RAIA: Thank you, Moe.

CHAIRWOMAN WEINSTEIN: Assemblyman Ra.

ASSEMBLYMAN RA: Thank you.

The point on marijuana -- and, you know, I know in your testimony you talked about the age of 25. This is an area that, like you said, should be looked at outside the budget, and we shouldn't be rushed.

But I do think from the perspective of the Medical Society there is important information that we should be considering, both in terms of what that appropriate age is, if we're doing this, and then also what the impacts are going to be and what that's going to require after the fact. Because one of the big conversations has been, Okay, where's the revenue going?

And, you know, there's been talk of investing it in communities and all that, which is all fine and good. But I think we have to first worry about what are the impacts that we're going to deal with both in healthcare and otherwise.

So do you have -- can you elaborate on that, thoughts from the Medical Society's

perspective on what in terms of healthcare we may have to invest in as a result of that legalization?

MR. AUSTER: Well, I think we have concerns about, you know, about the -- not necessarily to say it's a gateway drug, but we are concerned when we look at the vaping epidemic that's taking place in our schools now. Listen, I get notifications home from my school principals where my kids to go school about the significant amount of vaping taking place. And we're concerned about that type of message going forward, that it's okay to use marijuana at a younger age, and so we are concerned about it becoming more prevalent at that point.

I think we certainly need to see greater -- well, I will say one aspect of the Governor's proposal in that area which was positive, they do have some pretty strong standards around greater preventing of advertising that's conducive to youth. So that is a positive aspect of that proposal.

I think that's where we have the

biggest concern, is around the youth. But it's also being used -- I know there's a reference -- there's a concern about pregnant -- of use by pregnant women as well too, and how best you make sure that that does not end up being used by pregnant women.

Again, that's a tougher question, but I think frankly that's a topic that I think that -- why you need a more expanded level of discussion on that issue.

ASSEMBLYMAN RA: Thank you.

MR. AUSTER: Sure.

CHAIRWOMAN WEINSTEIN: Assemblyman Barclay.

ASSEMBLYMAN BARCLAY: Thank you, Chairwoman.

Hi, Moe. I just have a quick question. Does the Medical Society have any -- I know residency -- we heard from other testifiers about 10 percent of the students are educated in New York. One of the problems we have, obviously, is not enough residency slots in our hospitals. Does the Medical Society have any sort of

proposal to try to solve that other than, I guess, more money?

MR. AUSTER: Well, I certainly think we'd like to see an expansion of the Doctors Across New York program. We think it's been a good program for helping to do loan forgiveness and bringing physicians to serve in underserved areas of the State of New York. We'd certainly like to see an expansion of that program.

I do think, you know, there has been an increasing trend, though, that we've seen that's come from some of the medical colleges that New York is keeping less of residents than it once was. I think at one point it was 55 percent, now I think that number is in the low 40s -- at least that's a stat I remember from a report from a couple of years ago -- and that is a very concerning long-term trend.

I think it relates to a lot of different issues I can't specify, but New York has certainly had a reputation over the last several years of being one of the

worst states in the country to be a doctor. I think anything we can do to kind of help turn that around, whether it's on programmatic issues but also on resident recruitment -- expanding the Doctors Across New York program is certainly one way in which to address that issue.

But again, there's also other longer-term issues such as addressing some of the very difficult practice climates that doctors seem to find in the State of New York, and which is one of the reasons why so many doctors feel they've had to become employees of institutions as well, because of the challenges and what they perceive as the overregulation of the practice of medicine.

ASSEMBLYMAN BARCLAY: Thank you.

CHAIRWOMAN WEINSTEIN: That's it for us.

CHAIRWOMAN KRUEGER: Thank you very much for your testimony.

Actually, Bill Hammond is next up, because we've had a subtraction -- yes, Bill Hammond from the Empire Center. Then

1199 Service Employees International, get ready up at bat after Bill Hammond. And then we'll have a panel from pharmaceutical organizations.

Bill Hammond from the Empire Center. Some people thought we were just having a reporter walk in here.

MR. HAMMOND: Thank you for having me. My name is Bill Hammond, I'm with the Empire Center. I'm not here to ask for any money.

(Laughter.)

CHAIRWOMAN KRUEGER: Good. We don't have any. We're looking for 2.3 billion, if you have any extra. Sorry.

MR. HAMMOND: I guess I'd like to start by pushing back on the idea that New York's health funding is under some kind of attack in Washington.

I mean, I'm not going to deny that there have been -- that there are people who would like to attack it, and there's been proposals to attack it, but I think since the change in the leadership of the house I don't see any major cuts in Medicaid or changes to

the ACA happening.

And a lot of the cuts that we have been concerned about in New York have been either reversed or are likely to be reversed. The DSH cuts, for example, Disproportionate Share Hospitals, that's a cut that did not originate with the current leadership. It started with the Affordable Care Act in 2010. It's been postponed I think it's four times. It very well could be postponed again.

That said, it does make sense to prepare for losing that money, because it is actually in -- that is on the books, as things stand now. And I think one way to prepare for that would be to spend what you do have in DSH money on the appropriate services to the appropriate hospitals and the appropriate patients.

Right now, the first billion dollars of that money goes to the Indigent Care Pool. It's come up a number of times today that that program is not working. It's sending the money to the -- not sending the right amount of money to the right hospitals. And

the efforts to fix that are currently kind of in a holding pattern. It is disappointing that there was nothing about that in the budget proposal.

The Medicaid cap. It's due to be extended. During the period when our Medicaid enrollment was rising, it was a very stringent cap. Now that our Medicaid enrollment is flat, it's not doing very much to contain spending. In fact, it gives Medicaid kind of a pass on the overarching spending cap that the Governor imposes on the rest of the budget of 2 percent.

And on top of that, the executive branch has been carving more and more Medicaid spending out from under the cap. We're now to the point where it's -- I think it's $2 billion that's exempted from the cap. And a lot of that money is just going to very core expenses in Medicaid, such as salaries, so it doesn't make sense to me you would exempt that.

The universal access commission, I guess I'm a little surprised to hear how much

antagonism there is to that idea. It seems like -- I don't see what harm there could be in studying incremental or studying all range of solutions -- I mean, even if you are thinking of doing single payer, which I don't support, but even if you're thinking of doing that, it would take a number of years to implement, and I don't see anything wrong with doing more incremental fixes in the short term.

The IVF mandate -- I don't think it belongs in the budget. I haven't heard an argument for why it would belong in the budget. It goes beyond what's normally considered infertility, the way the bill is written -- the way the Governor's proposal is written and the way the Legislature's bill is written. It's probably more expensive than what you've been hearing from the proponents of it. And there's been a lot of talk today about the study, so I don't need to tell you about how that study is important and that you should have it before taking any action.

I guess the last thing I'd like to

bring up is the Healthcare Transformation Fund. It was created last year out of, I think, a misleading belief that our funding was under threat in Washington. Those threats did not materialize. We went ahead and created this fund. We changed the name to a Transformation Fund, and we gave the Governor extraordinary authority to spend $2 billion without consulting the Legislature or even notifying the Legislature.

There are a number of items described in the spending plan in vague terms about how he's using that money. One thing that we know concretely is that he's using it for a -- he's using this one-shot resource to finance a temporary increase in the Medicaid rate. That doesn't seem like a -- fiscally, this doesn't make sense to me, that you would use temporary resources to increase Medicaid rates.

But underlying that, I think the Legislature should bring this money back under the appropriating power that it has. It should also want to know exactly how the

Governor is spending the money that he has spent.

Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Any questions, Senate? Assembly?

CHAIRWOMAN WEINSTEIN: No, we're good.

Thank you.

CHAIRWOMAN KRUEGER: Thank you very much.

All right, next up, 1199 Service Employees International Union, and then there are -- just to keep track, right after 1199 will be three representatives of Pharmaceutical Care Management, Pharmacists Society, and Community Pharmacy Association.

Hi.

MS. SCHAUB: Hi. Thank you so much for having me. Good afternoon.

CHAIRWOMAN KRUEGER: Good afternoon.

MS. SCHAUB: Thank you for the opportunity to testify on behalf of the 300,000 members of our union in New York State who perform all sorts of healthcare tasks, caring for New Yorkers at home, in

community clinics, in hospitals, and in nursing homes.

A lot of the issues that I've raised in my written testimony have been raised in various times during this hearing, so I just want to flag a couple of issues to be as quick as possible, because I know folks have been very patient to sit through the day and there's a lot of people behind me.

So first of all, the funding issue. I know the providers really emphasize this. As an organization that sends our members to Washington to fight for funding, including to lobby to push off the DSH cuts, which we would be doing very aggressively this year, we do think that there are real threats and it is very important to not only fight then in Washington but to protect the funding that we have here, including the proposed increase in the Medicaid cap. We would urge you to protect that.

I know there's to be a discussion about potential actions because of the deficit that was announced yesterday, but

safety-net institutions in particular really are hanging on -- we know, we get the calls that say, We're not sure if we make payroll next week, and we're not sure how we keep the lights on. So we would really urge you to protect that funding.

In terms of the Indigent Care Pool, the Governor obviously did not propose anything in his budget. That pool has a methodology which expires this year. I guess it is possible to wait until next year, because the money runs through the end of this fiscal year, but it is something that you all could take on and decide to redo that methodology.

We are supportive of the folks who say it should be -- the legacy accounting of bad debt in that formula should be gotten rid of. Basically, it allows some of the wealthier institutions to get payment from an Indigent Care Pool who really don't need it, and frankly some of them even say they'd give it back if they could figure out how to do that.

But in revising the methodology, we

think it's important to really understand the impact on true safety nets -- like Brookdale Hospital in East New York, like Jamaica Hospital -- who see large numbers of uninsured and poor people. If the current methodology just expires, those hospitals will see very significant cuts, and there's an opportunity to revise that pool to make it much fairer but not to hurt the true safety-net institutions.

Just on the case mix index issue, which a number of people have raised on the nursing home side, again, we think it's fair that the case mix index formula actually reflects the case mix in the institutions and if there's a need to revise that to make sure that it actually does, that there's not some sort of gaming of the system, that's okay.

But $244 million is a very significant cut. And what we would urge the Department of Health to do, and perhaps with your insistence, is to create an industry workgroup that really understands what a methodology should be that accurately

reflects case mix and to let any savings dollars follow that good methodology, rather than starting with a number and potentially hurting a number of folks who really need those nursing homes to be fiscally sound.

I just wanted to flag, finally, on the consumer directed program -- there's been a lot of good questions about that. We see, from our perspective, some of the new entrants to this market, the 600 agencies that have shown up in the last six years since there was kind of an unfettering of participation in it.

These are not the traditional disability groups who have done a great job of making sure that program really served consumers and did it in a consumer-directed way. They're for-profit licensed agencies who showed up --- you know, some people called them LHCSA-lite, basically, because they thought they could make money in that program, and they have been able to do that.

We see them from the other side as we talk to unorganized homecare workers that --

people may have seen, three or four weeks ago, there was a front page in the Daily News about a home care agency owner who was arrested. I was just looking at the indictment and, you know, they're looking to freeze her assets, including her $250,000 Bentley that she purchased with ill-gotten gains from the home care industry. Those are the sorts of agencies that entered into this market because they saw they could make a lot of money.

I think setting up a contracting process that respects the traditional disability community providers and returns the program to them really could do a lot of good to make sure those services are preserved and they're delivered in a way that is consistent with the intent of the consumer-directed program.

Finally, I just wanted to flag that we are supportive of the proposals to strengthen the oversight of the Medicaid inspector general's office over managed care. We see a lot of problems with these rogue homecare agencies not paying, for example, according

to the wage parity law, et cetera. This would make sure that OMIG can reach in there and challenge those providers.

CHAIRWOMAN KRUEGER: Thank you. Thank you very much.

Senate? Assembly?

CHAIRWOMAN WEINSTEIN: Assemblyman Gottfried for a quick question.

ASSEMBLYMAN GOTTFRIED: Yes, thank you.

On the package proposed by OMIG, one of the items involves home health aides and other home health workers getting a federally based ID number. What does 1199 think of that?

MS. SCHAUB: So the only place that we know in the country that does that now is Washington, D.C., in their Medicaid program, and we've seen it work there. We haven't seen too many problems with aides being able to get that number.

Other states require aides to have an individual provider number, but it's provided by the state, not by the federal government.

So this is not necessarily unusual around the country, and at least our experience with our sister locals is that it's something that's workable. Certainly we would work with our members to make sure that they were able to get the number.

ASSEMBLYMEMBER GOTTFRIED: Okay. If in the next couple of weeks your thinking shifts on that, be sure to let us know.

MS. SCHAUB: We will, for sure.

ASSEMBLYMEMBER GOTTFRIED: Okay.

CHAIRWOMAN KRUEGER: Thank you very much for your testimony today.

And next up, the panel. I'll read off everyone's name, maybe even correctly. Pharmaceutical Care Management Association, Lauren Rowley; Pharmacists Society of the State of New York, Steve Moore; and the Community Pharmacy Association of New York State, Mike Duteau.

Hi. And there is a report. Okay, wow. Okay. You each get five minutes, although there are four of you here. Oh, I'm sorry, I missed Debbi Barber -- excuse me --

of the Pharmacists Society.

So you each get five minutes, so that's five, five, and five. Right? Three groups, so five, five, and five. But the reason we called you all up together was the theory that if we did have questions relating to what you were all testifying on, if you're all there together, it makes the question process a little more logical. That was our thinking.

So we start with Lauren Rowley.

MS. ROWLEY: Is my microphone on? Okay.

(Off-the record discussion.)

MS. ROWLEY: Okay, is it on now? Okay, sorry. I'm eating up time here.

Thank you very much for the opportunity to be here today. My name is Lauren Rowley. I'm the vice president of state government affairs for the Pharmaceutical Care Management Association, representing the PBMs in the state and also nationally.

Our PBMs administer prescription drug

benefits for over 266 million Americans with our clients that are employers, health insurance plans, labor unions, state governments, Medicaid and Medicare. It's my privilege to testify today before you, and I will be happy to answer any questions.

PBMs exist solely for the purpose of reducing drug costs and providing safe and effective low-cost drugs to consumers. None of the PBM clients I mentioned earlier have to contract with PBMs. They do so because of the proven savings that they see through the contracts with PBMs. But again, they do not have to -- nobody has to contract with a PBM.

But through the wide array of services and tools that lower prescription drug costs, we are able to provide patient access and adherence to prescription medications. In fact, according to new research, we are projected to save $40 billion over 10 years in New York alone. PBMs reduce drug costs by encouraging the use of generics and affordable brand medication. One of the ways we do this is by driving competition where it

doesn't naturally exist within the pharmaceutical manufacturing industry.

After the PBMs and the pharmacy and therapeutics committee determine that a drug may be on a formulary, or the health plan's P&T committee determines that, the PBM, through arm's-length negotiation, is able to make the drug companies compete against one another for placement on a plan formulary.

Again, this competition doesn't naturally exist in the marketplace, this is driven solely by PBMs. Those rebates are passed back to the plan to reduce patient premiums. Through their contracts with PBMs, the plan is able to audit the PBM to ensure the rebates attributable to their utilization are being passed back. And I think that it's important to note that they are able to see what rebates they are entitled to under their contracts.

However, these negotiations with manufacturers require confidentiality or nondisclosure to the public. The FTC and the Congressional Budget Office have issued

strong statements and opinions about the need for this confidentiality.

Unfortunately, these negotiations have made it easy for some to portray PBMs as opaque middlemen. However, the secret to high drug prices is no secret. Pharmaceutical prices start and end with the manufacturer.

As I mentioned, our entire business is predicated on lowering drug costs. In fact, two years ago when this proposal was first introduced, your Medicaid director, Jason Helgerson, made sure that this did not apply to Medicaid managed care plans because he knew that this proposal would affect PBMs' ability to secure rebates and operate effectively and would ultimately increase costs under the Medicaid cap.

He was further asked about the problematic PBMs and refuted that they were a problem and said that PBMs are the basis for effective rebates that ensure Medicaid members have access to the drugs they need.

Specific to the PBM provisions in the

Executive Budget, PCMA urges you to reject Part 1 of the HMH bill. This section gives unfettered discretion, sole discretion to the DFS to have oversight over PBMs and unlimited discretion to disclose proprietary financial information not only of PBMs but their clients, which I mentioned earlier has been discussed by the FTC and the CBO.

While our analysis shows that this proposal would increase costs, the state hasn't assigned any fiscal to it, which highlights that it simply is not a budget issue and doesn't need to be dealt with in this process. We believe that DFS is using the budget to force its policy opinion on the Legislature. We urge you to reject the Governor's proposal and work on this post-budget.

As many of you know, these PBM bills have been worked on in NCOIL and at NAIC -- in fact, some of the members from this body have participated in that process. And while we weren't happy, necessarily, with the outcome of those bills, all the stakeholders

were brought to the table -- the PBMs, the pharmacies, the health plans, and the manufacturers -- to come up with a bill that all the stakeholders had some position in.

So again, we urge you to reject the Governor's proposal that would instead give unfettered discretion to the DFS.

With regard to -- so actually, the spread pricing issue, I'm happy to answer any questions on that, but I'd like to go on to the proposal -- the study that's been brought before you. While much has been made of the Ohio audit and the need for spread pricing reform, we wish to highlight that the Ohio analysis found that PBMs still saved Ohio Medicaid $145 million through PBM management compared to what they would have had to spend under fee-for-service.

And unlike the analysis prepared by PSSNY, DOH's own analysis assigned a fiscal savings target --

CHAIRWOMAN KRUEGER: All right. Thank you.

Next, we have Pharmacists Society of

the State of New York.

MS. BARBER: Good afternoon, and thank you for allowing me to testify.

Honorable Assemblywoman Chair, Senator -- excuse me. Honorable Finance Chair Senator Krueger and Honorable Ways and Means Chair Assemblywoman Weinstein, Senator Rivera, Assemblyman Gottfried, and distinguished members. My name is Debbi Barber. I currently serve as the president of the Pharmacists Society of the State of New York. With me today is Steve Moore, our society's president elect.

You have our written testimony before you. In consideration of your time and that of the witnesses coming afterwards, I will keep my remarks brief.

The Pharmacists Society is a 140-year-old statewide organization with regional affiliates throughout New York. The society represents the interests of over 25,000 licensed pharmacists who practice in the State of New York in a variety of settings. Most of PSSNY's members are

community pharmacists, and many of them are independent owners.

First we would like to say thank you to so many of you who have shown support for pharmacists in previous budget decisions and in votes for legislation that have been important to us. Our society is also pleased that this year the Governor has included legislation in his Executive Budget to finally rip the veil off the unnecessary middlemen known as PBMs, or pharmacy benefit managers.

And while transparency is important, our fear is the proposed solutions will only tell us what we already know. PBMs are taking advantage of our pharmacies and our state. Our written testimony includes a study conducted by PSSNY last month which shows hundreds of millions of dollars being stolen from Medicaid and pharmacies across the state.

As I sit before you right now, pharmacies across the state are being short-changed and paid below cost on the tens

if not hundreds of thousands of prescriptions being filled and dispensed to the most frail, disabled, and chronically ill New Yorkers.

We appreciate all of the proposals in the Executive Budget, but all you need to do is Google PBMs and states, and you will see that New York is already behind other states in regulating this industry. Yes, we need transparency and regulation. Please pass it now. But we also need to reform the Medicaid managed care system by removing prescription drugs and moving back to a fee-for-service model.

Just last month, the first executive order signed by the new California governor, Gavin Newsom, was to make his state the largest purchaser of prescription drugs, moving to a fee-for-service model by 2021. We can and should do it here in New York.

In the context of a pharmacy benefit, managed care has produced exactly the opposite of the quality and efficient spending it was designed to yield. Rather than an open competitive market, MCOs, or

managed care organizations, have become a tool PBMs have used to hide behind before fleecing the State of New York's Medicaid system and robbing your local pharmacy, pocketing the savings for themselves, driving competition out of business, and delivering quarterly profits to Wall Street.

The dominant PBMs are all Fortune 25 corporations which we allege engage in anticompetitive, monopolist, predatory behavior. You have passed so many meaningful pieces of legislation in the last month, many of which have languished for years. New York is once again a leader in the nation when it comes to legislation. Let's not allow other state to reform their systems, save money, provide better patient care, provide better delivery of prescription drugs to patients, and leave New York playing catch-up.

New York has an opportunity to be a progressive leader by saving community pharmacy and moving to the fee-for-service model for prescription drugs. We need your help now, working together with all of you,

to ensure our community pharmacies can remain viable for the patients of the State of New York.

Thank you, and we are open to any questions that you have from our written testimony.

CHAIRWOMAN KRUEGER: Thank you.

And then the third panelist is Mike Duteau of the Community Pharmacy Association.

MR. DUTEAU: Thank you so much. Can you hear me?

CHAIRWOMAN KRUEGER: Yes.

MR. DUTEAU: Thank you.

So Honorable Chairwoman Krueger, Senators Rivera, Seward, Assembly Members Barclay, Cahill, Raia, and other distinguished members of the panel, my name is Mike Duteau. I am a pharmacist, I am an employee-owner of Kinney Drugs, and I am president of the Community Pharmacy Association of the State of New York.

We certainly want to thank you again for all of your strong past support of community pharmacy and, again, for the

opportunity to testify today regarding this year's budget.

The Community Pharmacy Association of New York State represents pharmacies of all types and sizes throughout the state. Together, we are focused on protecting patient access to pharmacy care and strengthening the role that pharmacists can play in improving patient health outcomes while reducing costs. In this regard, we would like to comment on four specific budget proposals, and I do promise to be succinct.

First and foremost, the Executive Budget released on January 15th includes two proposals to regulate pharmacy benefit managers. We support both.

The first includes a series of provisions that would require registration and licensure, reporting requirements around incentives. It would also assess PBMs for operating expenses incurred by DFS for oversight and regulation, and it also states that failure to comply with such requirements could result in revocation of registrations

or licenses.

Again, we support the need to regulate PBMs. They are currently the one entity in the entire healthcare continuum that is not regulated. Pharmacies, wholesalers, manufacturers, hospitals, long-term care facilities, health insurance plans, and other health provider groups are also regulated, registered, and licensed. We believe that registration and licensure are an important first step in regulating PBMs and, most importantly, in lowering the cost of prescription drugs.

The budget also includes a second PBM-related proposal specific to Medicaid managed care. Essentially, it requires that contracts between health plans and PBMs would be limited to the actual ingredient costs, a dispensing fee, and an administration fee for each claim process, which of course would be established by Department of Health. In essence, this proposal would make it a pass-through or a fully transparent model, and we fully support that proposal.

Again, referenced by the other two panelists, similar to the findings by the Ohio Medicaid department, a study recently conducted by the Pharmacists Society of the State of New York appears to validate that large national PBMs may have misappropriated taxpayer dollars in the interest of their own financial gain. The state must act to prevent this egregious practice, and we firmly believe that this budget proposal will help ensure a transparent pricing model that will lower costs for patients as well as for the state.

We also welcome the opportunity to work with you to consider whether additional safeguards may be needed to ensure that PBMs cannot lower pharmacy reimbursement or utilize other strategies to comply with this proposal that could negatively impact community pharmacies and the patients who rely on us for often life-saving pharmacy services.

Secondly, the budget includes a proposal to increase copays in Medicaid

over-the-counter drugs. We oppose this proposal. We feel raising the copay from 50 cents to $1 in many cases could make these products unavailable and unaffordable for Medicaid patients. Ultimately, if they go without these products, they could drive up the cost to the state by requiring more expensive prescription drugs, worsening health conditions, perhaps even causing hospitalizations.

Furthermore, patients enrolled in Medicaid have the ability to refuse to pay copayments. Our members do report the nonpayment of copays and, in many cases, extremely high rates of uncollectible copays. As a result, community pharmacies would be bearing these additional costs, further reducing pharmacy reimbursement, which can be just or at even below our actual cost. For these reasons, we respectfully urge the Legislature to reject this proposal as you have done previously.

Thirdly, also tied to over-the-counter Medicaid coverage for drugs, there's a

reduction in what Medicaid would cover. In our opinion, we are concerned that Medicaid would no longer cover these products and the result would be that patients again would no longer be able to afford to purchase them on their own. As a result, this could jeopardize patient access to needed medications and, again, ultimately their health. We urge you to reject this proposal in the final budget.

And finally, while not in the budget, we would oppose any proposal to establish an opioid assessment or tax that could be passed down to pharmacies or patients.

Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Questions from the Senate?

Yes. Senator Gustavo Rivera.

SENATOR RIVERA: Hello. Since I only have five minutes for everybody, I'd like to start with the lady on the right of me. I forgot your name, I'm sorry.

MS. ROWLEY: Lauren Rowley.

SENATOR RIVERA: Mind if I call you

Lauren?

MS. ROWLEY: That's fine.

SENATOR RIVERA: Because I can't find your last name. So anyway -- okay, Rowley. Rowley. Ms. Rowley.

So, Ms. Rowley, obviously you have a fundamental disagreement with the argument that was made by some of the folks to your right. So in a nutshell, if you could explain to me -- and for the record -- how is it that a pharmacy benefit manager saves money. Because there are arguments that you made a couple of times around the amount of money that was saved, including some of the studies that are in our hands, which obviously we haven't read because it's like, you know, hundreds of pages.

So in a nutshell, tell me how it is that a PBM saves money.

MS. ROWLEY: Here's the nutshell. So again, we're aggregating millions of lives. And I talked about one way we do that with pharmaceutical manufacturers.

The other way we do it, frankly, is by

our contracting with pharmacies. And we do require that they be part of the cost savings for consumers. In order to be part of the pharmacy network, they have to accept certain reimbursement rates, et cetera, but for that they become part of the pharmacy network.

So those are kind of the two biggest ways. There's a lot of other services, a lot of adherence programs that we initiate. We also do safety with drug utilization review. There's a number of services that are within the toolbox that PBMs offer. You know, keeping in mind that clients actually put out the RFP that the PBMs respond to, so they're the ones who are actually designing the benefit and saying this is how much money we have to spend on it.

Hopefully that answers your question.

SENATOR RIVERA: In a nutshell, it does.

So to switch up -- I'm obviously going to dig into the study at a later time. And it was already made available to me, I haven't gotten to read the thing, but

obviously it's important to consider.

(Clock chimes.)

SENATOR RIVERA: No, I'm not done.

(Laughter.)

CHAIRWOMAN KRUEGER: Ignore that for the moment.

SENATOR RIVERA: I heard the thing, I thought it was like somebody's phone is ringing or something, I don't know.

So in the same vein, you have a fundamental disagreement with what the lady just stated. As far as the study is concerned, tell me in a nutshell what the study says about what the PBMs actually -- oh, this is the gentleman who wrote the thing.

MR. MOORE: I did not write it, no. I'm a poor substitute for Eric, but I'll do my best.

SENATOR RIVERA: Okay.

MR. MOORE: The study in a nutshell points out that there is a level of transparency needed in this market. We have costs that are identified as pharmacy costs,

and those monies are not going to the pharmacies.

So the study does not necessarily identify that if a prescription is filled at average cost -- in this case it's $14.36 -- and the pharmacy only gets $10 or $11 of that, where's that spread going, you know?

New York is very interesting because of the size of our Medicaid program. If you take the 24 percent spread that the study found -- and the study was not a claim-level-detail analysis, an exhaustive analysis of every prescription in New York State. We're not representing it as that. But if you look at the 24 percent of potentially $1.3 billion, you're looking at potentially $300 million worth of spread that was reported as pharmacy cost.

Often, you know, we're finding more and more that our pharmacies are being paid below their cost for these medications they dispense. So it's not an issue of pharmacies not wanting to be part of the cost savings or not wanting to be part of the solution to

controlling healthcare costs, but it's an issue of our members not able to be financially viable.

So we have some examples of that. If you look at the third tab in our study -- so this is a medication that's called Tacrolimus --

SENATOR RIVERA: It's got tabs.

MR. MOORE: It's got tabs. We tried to make it easy for everybody.

It's called Tacrolimus, 5 milligrams. This is a drug -- it's an anti-rejection drug used after transplants. It's commonly dosed twice a day.

So these lines -- this blue line represents NADAC, which is a national survey of pharmacy acquisition cost, the red line represents pharmacy reimbursement, and the orange line represents the charge to the state.

Now, this is all on a per-unit level, and it's an average over a period of two years. We survey this quarterly. You can see that towards the end of 2017, the blue

line started to go below the red line, so our pharmacies are actually starting to lose money on these prescriptions. Unfortunately, this happened to be about the same time a lot of these entities started talking about buying one another.

So, you know, we do have some concerns about that. We have concerns about letters that many of our members received offering to buy out their pharmacy due to challenging financial conditions. And as you can see right now, those challenging financial conditions were imposed by those same entities that are offering to buy the stores.

CHAIRWOMAN KRUEGER: Thank you.

Assembly?

SENATOR RIVERA: I thought that they could -- I'm actually --

CHAIRWOMAN KRUEGER: Oh. You know, he has 50 seconds.

SENATOR RIVERA: I could then very slowly say that I am -- I am -- I am good.

(Laughter.)

SENATOR RIVERA: Thank you, Madam

Chair.

CHAIRWOMAN KRUEGER: Sorry.

CHAIRWOMAN WEINSTEIN: Assemblyman Raia.

ASSEMBLYMAN RAIA: Thank you.

The first question is for Ms. Rowley. A simple yes or no; if you want to explain, you can. Are there instances in which pharmacists are reimbursed less than the cost of the drug?

MS. ROWLEY: That can happen, but there are also instances where they get reimbursed above the cost of the drug.

And I do have some strong opinions about this study that I would certainly like a moment to address, if I could, which is they only looked at 11 pharmacies in the state out of nearly 4800 pharmacies in the state. They didn't take into consideration any of the chain pharmacies in the state, which represent 44 percent of the pharmacies in this state.

So I would hope that you would remain skeptical of these findings, and --

ASSEMBLYMAN RAIA: I'm hoping to start a cage match.

(Laughter.)

MS. ROWLEY: I'm way outnumbered.

ASSEMBLYMAN RAIA: Now, hold on. Now, Mike -- how do you say it?

MR. DUTEAU: Duteau.

ASSEMBLYMAN RAIA: You mentioned the tax on the opioids. Now, that initially -- we all thought that was just going to the wholesalers or the manufacturers. So now that a year has passed, can you tell me what the impact has been on your industry as the retail end, I guess?

MR. DUTEAU: So fortunately, again, based on your actions last year, we've had no impact because pharmacies and patients were spared the assessment.

We are concerned because on December 19th a judge struck down the law. That could have ramifications that again could trickle down to us. So I didn't get a chance to fully elaborate. We're just opposed to any new type of assessment that

could again impact pharmacists and our ability to care for our patients.

ASSEMBLYMAN RAIA: Thank you. And that's it, I'm done ginning up the crowd.

CHAIRWOMAN WEINSTEIN: Assemblyman Cahill.

ASSEMBLYMAN CAHILL: Hello. I first do congratulate you all for sitting there and being nice to each other. The audience can't see your faces -- we can.

(Laughter.)

ASSEMBLYMAN CAHILL: So, Ms. Rowley, just to start with, does your organization have as one of its members CVS Caremark?

MS. ROWLEY: Yes, we do.

ASSEMBLYMAN CAHILL: Earlier it was disclosed that CVS Caremark has indicated they would not oppose the Governor's proposal, but your testimony indicates that you're opposed to that proposal. So is CVS saying we're not going to do it but our organization still will?

MS. ROWLEY: I can't speak for specific member companies. We have more

than -- we have 16 member companies, actually, and our opinion and our position on this is that it's better handled post-budget within the legislative process.

ASSEMBLYMAN CAHILL: Well, I don't necessarily disagree with that. But I was curious as to what seems to be a difference of opinion within the industry as to whether the Governor's proposal is a good one or not.

The largest PBM in our state is Caremark, and they said they don't oppose this. And then their industry representative comes into a hearing and says "We oppose this." That's kind of like a little confusing of a message. Which one should we believe, you or them?

MS. ROWLEY: Well, I would believe me, on behalf of industry, that is our position --

ASSEMBLYMAN CAHILL: I believe you. I believe you are against it.

MS. ROWLEY: And I think that CVS Health will be happy to be part of the negotiation process should you move it to the

legislative body after the budget.

ASSEMBLYMAN CAHILL: Yeah. It appears that they might have already been part of a negotiating process, because they already indicated that they don't object to something and they indicated that before we in the Legislature saw the specifics. So somebody was at the table.

But thank you very much. Just a point of interest. I do not necessarily support the idea of substantive matters that are not directly related to the budget to be part of our budget negotiation. It is -- perhaps was necessary in a different time, in a different era when there were different players, when there were different people in the room, so to speak.

But right now we have a Legislature that has demonstrated, since the first session in January, that we are fairly united in advancing progressive policies for New York State and we may go forward on our own in a way that could exceed what the Governor has been willing to do or what he

might have negotiated with CVS Caremark and others.

Is there any reason those of you who represent the community pharmacies or the neighborhood pharmacies, the independent pharmacies -- any reason that you believe that it's absolutely necessary to do in the budget?

MS. BARBER: I think the biggest concern there would be is that there is back-and-forth and it falls apart and we don't get anything at all.

ASSEMBLYMAN CAHILL: Right. And in terms of what the Governor proposed, are you wholly on board with everything that he's proposed? Is there anything that you would add, anything you would take away?

And you can answer me now if you have the information and can convey it in one minute and 56 seconds. But if you can't, I'll be happy to take something in writing on that later on.

MS. BARBER: We can do that for you.

ASSEMBLYMAN CAHILL: Okay. Thank you.

MR. DUTEAU: We certainly can provide some additional information. We are happy, our community association is happy with the budget proposal at this point.

We do have chains, to answer the previous question. We do concur with the PSSNY study, our membership has taken a look at it. We do not have all chains -- CVS Caremark is not a member of our association -- but we are happy with the budget proposals as stands, and we would also be happy to participate in additional conversations regarding legislation later if necessary.

ASSEMBLYMAN CAHILL: It just got even more confusing. Caremark is not part of that organization that opposes the bill, Caremark is part of the organization that supports the bill --

MR. DUTEAU: They are not part of our association.

ASSEMBLYMAN CAHILL: Caremark is not part of your association.

MR. DUTEAU: CVS Caremark is not part

of our association.

ASSEMBLYMAN CAHILL: But you're consistent with their position that the Governor's proposal is a good idea, and you're inconsistent with the position that the Governor's proposal is a good idea. So I understand completely.

(Laughter.)

ASSEMBLYMAN CAHILL: Needless to say -- and I would ask this, put this to the PCMA rep, Ms. Rowley. Do you believe that it's time to do regulation and licensure of PBMs? Or do you think it's not going to be that time now or ever?

MS. ROWLEY: I believe it's a good time for discussion. I think we had a good discussion, Assemblyman, at NCOIL over this very issue over the course of a year. I think it's not an easy solution or answer. You know, the devil's always in the details, and you have to make sure that you're not doing anything that's going to ultimately raise the cost to consumers. And I think that's really what we want to prevent from

happening. But I think having a conversation with all the stakeholders is important and relevant.

ASSEMBLYMAN CAHILL: Great. Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Senator Metzger.

SENATOR METZGER: Yes, hi. I have a concern about this bend towards prescriptions by mail, and I want to know, is this being driven by PBMs? What are the drivers of that? And also, has anyone looked at the impacts of those changes on patient health?

And -- yeah. That question -- I could direct that actually at -- I wouldn't mind hearing both sides.

(Laughter.)

MS. BARBER: So it definitely is impacting the community pharmacies. We talked a little bit about anticompetitive in our testimony. They are directing them to their own mail-order pharmacies that the PBMs do own, oftentimes not allowing the independent owners or the other community

retailers to be able to even join those networks.

There have been studies, and it's very clear, when we have the drug take-back programs, the amount of waste that is brought back into those programs that are just directly from mail-order facilities.

MR. DUTEAU: And I would agree. We have the same experiences.

You know, also when it comes to those networks, oftentimes either we are excluded from participation or, if we are offered one network, it comes with a caveat: If you refuse this one, you're out of all of our networks. That's not an uncommon tactic.

MS. ROWLEY: Senator, might I point out that your state law actually allows any pharmacy that's willing to participate with the same pricing terms and conditions as mail order are able to participate at 90-day fill.

MR. MOORE: That law doesn't apply to every plan, though. ERISA plans are excluded from that. (Inaudible.)

MS. ROWLEY: I would actually argue

that ERISA plans are exempt from state law.

ASSEMBLYMAN CAHILL: Calm down.

(Laughter.)

CHAIRWOMAN KRUEGER: Assembly?

CHAIRWOMAN WEINSTEIN: Yes.

Assemblywoman Byrnes.

ASSEMBLYWOMAN BYRNES: Thank you very much.

I want to just take this into a different vein as long as we have four experts in the field here right now. This was a question posed by one of my constituents about a month ago, and that is in reference to humans and pets. That their experience was, when they went to a pharmacy and got a prescription and the pharmacy thought it was for a human being, the cost was over $700. When they complained and they realized that it was a prescription for the dog, it became less than $100.

And do you have any idea -- and you may not know it off the top without thinking about it -- why the same prescription, same everything, but human being versus dog, would

be $700 difference?

MS. ROWLEY: There could be any number of reasons for that, Assemblywoman. It could be that that drug is not a covered drug on the formulary for the human. I just don't know. I can't specifically speak to why that would happen. I don't know. I'm sorry.

ASSEMBLYWOMAN BYRNES: They were pretty upset. And so as long as I have four experts, I'm asking. Thank you.

MS. ROWLEY: Okay.

CHAIRWOMAN KRUEGER: Sorry. Senator Bob Antonacci.

SENATOR ANTONACCI: Thank you.

In my district Kinneys is pretty prevalent -- syracuse, New York -- and one of your representatives had approached me about an interesting idea where maybe pharmacists could be more active in the healthcare decisions.

Rather than somebody going to an emergency room -- I think the example they used is like coming in, you had a flu shot or you think you might have the flu, you take

the temperature, if you don't have a fever, you don't need to go to the emergency room. And I'm not a doctor, so I'm not sure that's the exact example. But I guess my question to all of you would be -- and you don't have to give me a full answer today, you can also submit it in writing -- let's look for some ideas where we can save money on the system, where if a pharmacist with six or seven years of education can say, Wait a minute here, you don't need to go to the emergency room, or any other situation you can come up with -- let us know what those are.

If we have to pass legislation to enable that, I would think that's pretty sensible within the guise of your, you know, malpractice insurance, obviously. But please, please let me know. And if you want to talk about a couple now, great. We've got -- you have got 4 minutes, or you could send them to me in writing.

MR. DUTEAU: Sure. Thank you, Senator. Yes, I think you might be referencing one of our initiatives which was

CLIAwaived testing, rapid flu and rapid strep. And certainly nights and weekends, that was very valid for people that could come in and we would work very closely, obviously, with their primary care physician and our local hospitals to ensure that they received the highest level and most appropriate care.

But it's certainly a viable option. We're continuing to have conversations, again, with our colleagues at the Medical Society. Other pharmacies certainly offer similar services. And I know there's been a great deal of conversation around CLIAwaived testing specifically that I think would really benefit all of our communities.

CHAIRWOMAN KRUEGER: Thank you.

Assembly?

CHAIRWOMAN WEINSTEIN: None here. We're finished.

CHAIRWOMAN KRUEGER: So you're finished, okay.

Senator Seward.

SENATOR SEWARD: I had a couple of

questions for Ms. Rowley and then the whole panel.

You mentioned -- I think you used the word "clients" that you -- I mean, your customers -- I mean, in terms to follow up on what Senator Rivera said in terms of where you get your revenue, is that -- could you describe who these clients are? Obviously it's the health plan --

MS. ROWLEY: Sure. It's the health plan, employers, state employee plans, other public programs, unions, Taft Hartley --

SENATOR SEWARD: Yeah, major --

MS. ROWLEY: Correct. Very large, sophisticated purchasers of healthcare.

SENATOR SEWARD: Right. Now, are all of your members publicly traded corporations?

MS. ROWLEY: I believe all of them are, yes.

SENATOR SEWARD: And they have to report financials.

MS. ROWLEY: Yes, sir. Under SEC rules they all have to file 10K filings, which basically shows all the financial

information for the year.

SENATOR SEWARD: So there's -- these are publicly available?

MS. ROWLEY: Correct.

SENATOR SEWARD: Now, no question, in my years that I have chaired the Insurance Committee in the Senate up until this new assignment, I -- you know, no question one of the largest single growth portions of the healthcare costs and health insurance costs is in the area of prescription drugs. And it's important to hold down costs. So this is my question to the whole panel. First to you, Ms. Rowley, then the rest of the panel.

Does -- by following your viewpoint in terms of not going forward with the Governor's recommendations here, does that hold down costs and help to alleviate, you know, the ever-escalating health insurance premiums for our constituents in New York State?

MS. ROWLEY: I think it definitely holds down costs. Because as I mentioned, a lot of the information -- the SEC and the OBM

have commented that disclosure of that rebate information to the public will lead to tacit collusion amongst pharmaceutical manufacturers, basically not allowing PBMs then to negotiate fairly with them.

I think the one missing factor, frankly, from all of this discussion is the pharmaceutical manufacturers themselves. I was just doing a little research before this and noticed that Avi raised their prices by 9.7 percent in January of this year; Allergan raised theirs on 50 drugs in January; GlaxoSmithKlein raised their list price in January on 36 different drugs; Pfizer raised their price on 41 different drugs.

That is completely outside of the control of the PBM. Our role is then to try and step in and try to negotiate rebates so that we can actually hold down the price. And they will say there's a direct correlation, we have to raise our prices because we collect rebates. There's absolutely no correlation between the list price that they charge and what -- and the

rebate. There is none that has been studied.

So I believe that -- to answer your question, I do think this proposal would raise prices. I think the unfettered ability of the superintendent to do basically whatever they want with regard to PBMs could absolutely be harmful to the marketplace.

SENATOR SEWARD: And I would ask the rest of the panel members the same question. I mean, by going forward with the Governor's proposal, how does that hold down costs and help to alleviate the growing increase in health insurance premiums?

And by the way, I always have the option of mail order, but I never go that route. I always go to my local pharmacist.

(Laughter.)

MR. DUTEAU: So I'd have to say that, Cynthia, I would respectfully disagree with the previous answer. I feel that anytime you add transparency to healthcare, you are able to generate savings.

And I certainly understand that PBMs do play an important role in healthcare.

What we're asking for is parity. They should be at the same level as everybody else who is registered and licensed. And I think at that point you now have a great first step to ensure a level playing field, and you're able to examine every cost point in the healthcare continuum and focus on where you feel you can improve it the most. Because at the end of the day, you cannot improve what you cannot measure.

And I understand that there are SEC filings and there are financial reports. I've seen them, they're extremely vague. To get to the level of detail to fix this problem, we need better transparency.

Thank you.

SENATOR SEWARD: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

I think we are done. I want to thank you all for being on this panel. I didn't do it by accident, even though it made you uncomfortable. I think we all need to look hard at this report you've submitted and the arguments pro and con, but I do think the

State of New York better figure this out and do something. Thank you very much.

Our next testifier is New York Health Plan Association, Eric Linzer, followed by, just for people who are keeping track -- okay, no wildness, take it outside, men.

(Laughter.)

CHAIRWOMAN KRUEGER: Sorry. Just for keeping track, afterwards, Steven Sanders, Agencies for Children's Therapy, then the American College of OB-GYNs. So that's the next three.

New York Health Plan Association, hi.

MR. LINZER: Thank you, Madam Chairwoman. Chairwoman Weinstein, Chairman Cahill, members of the Senate and the Assembly, my name is Eric Linzer. I'm the president and CEO of the New York Health Plan Association. With me today is Kathy Preston, our executive vice president. We're here today to testify on several provisions in the proposed 2019-2020 Executive Budget.

In the interests of time, we have submitted written testimony and appreciate

the opportunity to offer comments on a limited number of issues.

By way of background, our members -- we represent 28 health plans that provide coverage to 8 million New Yorkers. These are folks who get their coverage through an employer, both large and small, as well as individuals who purchase coverage on their own, as well as the millions of individuals who receive coverage through one of the government-subsidized programs, including Medicaid and other such programs.

Specifically, we're opposed to -- we are concerned with Part B of the Executive Budget, which would place restrictions on contracting arrangements between health plans and PBMs. As you heard from the earlier testimony from PCMA, there's a concern that prescription drug prices are one of the major cost drivers to rising healthcare costs. Our concern with this particular provision is twofold.

One, mandating specific types of or prohibiting specific types of payment

arrangements will do nothing to address underlying healthcare costs.

And second, the projected savings that -- the Governor's budget includes $86 million in savings. It's unclear to us how that restrictions on contracting arrangements would necessarily translate into those savings and instead will ultimately result in a rate cut to Medicaid health plans.

Second, we're concerned with the number of the proposed mandated benefits included in the Governor's budget. And while well-intentioned, I think as you heard throughout the course of today's conversations, mandated benefits ultimately lead to higher healthcare costs for employers, particularly small and medium-sized employers who because of their inability to self-insure are therefore required to cover state-mandated benefits.

With that, I'll turn our testimony over to Kathy to provide some additional thoughts and perspective on some of the specific Medicaid provisions, and then would

be happy to take any questions from the committees.

MS. PRESTON: Good afternoon, everyone.

Just to take one step back, the Governor's Medicaid redesign effort, which started in 2011, the central principle there was care management for everyone. So in January of 2011 there were 2.9 million people in Medicaid managed care. By January 2019, there were 4.7 million people in managed care. So that's over 60 percent growth. Just so that you know, we are a big piece of how Medicaid services get delivered in New York State.

A lot of the proposals in the Governor's budget related to managed long-term care. And while we generally support all of those proposals, we are very concerned about how the savings will be taken. The intent is to take savings up-front, $268 million worth, out of MLTC premiums, before any reforms are actually implemented.

The first of those is the limit on fiscal intermediaries and paying fiscal intermediaries in the consumer-directed program a per-member per-month payment.

First of all, we believe that the consumer-directed program is an essential part of the long-term care continuum. We also believe that limiting the number of fiscal intermediaries and paying PM-PM -- per-member per-month -- reimbursement is necessary to maintain the integrity of the program. However, we are very concerned that the plan of the state is to take $150 million out of the premium before any reform happens.

Likewise, there's a proposal to change regulation to give plans more flexibility to give members services that they need in in-home care. We support that. We're a little concerned about how it gets implemented. And we're very concerned that they're going to take $50 million out of premiums before any reforms take place.

Likewise, there's a state office for the aging proposal to expand community

services to folks in an effort to divert some people from qualifying for and enrolling in a managed-long-term care plan. While we support the idea and think it's a good idea, we don't think it's a good idea or fair to the plans to take $68 million out of plan premiums before anything happens.

So I'm happy to answer any of your questions.

CHAIRWOMAN KRUEGER: Anyone? Assembly?

CHAIRWOMAN WEINSTEIN: Assemblyman Garbarino.

ASSEMBLYMAN GARBARINO: Thank you.

Just -- you said mandated benefits equals mandated costs. I talked about it before with the superintendent or somebody from the DFS. He didn't have an answer as to what the increase in premiums would look like. Do you have an idea of what these proposals under the budget would do to premiums?

MR. LINZER: We haven't costed those out yet, Assemblyman. I think the concern

becomes that while most folks will look at individual mandates and the cost of specific mandates may be in some instances relatively small on a per-member per-month basis, you know, the fact that New York has more than two dozen state-mandated benefits, those costs ultimately add up and lead to higher healthcare costs for employers and consumers.

I think the big concern -- again, regardless of whether or not a particular mandated benefit may be well-intentioned by a particular group -- is the fact that disproportionately small and medium-sized businesses are the entities that bear the brunt of those costs.

Large self-insured companies are subject to provisions under federal ERISA law and therefore are not subject to state mandated benefits.

And as we see more and more of the commercial marketplace moving towards self-insured arrangements, the impact of state-mandated benefits has a smaller and smaller benefit result on consumers, but it

has a potentially large cost implication for those small and midsized employers that are required to include them as part of their coverage package.

ASSEMBLYMAN GARBARINO: Okay, thank you.

CHAIRWOMAN KRUEGER: Thank you.

Senator Savino.

SENATOR SAVINO: Thank you.

Good afternoon, guys.

I just want to go to the issue of adding IVF coverage under small or large plans. We now are at a point in history or in medical history where infertility is a diagnosed condition and modern science has figured out a way to treat that. So is there any other condition that is a medical condition that insurance doesn't cover?

MR. LINZER: I would have to go back and give that some thought, Senator. I mean, to my knowledge I can't come up with an example at the current moment. But we'd be happy to give some thought to that and send follow-up comments to you.

SENATOR SAVINO: Because I would think that if it's a medical condition just like any other disease state, and you have insurance that's supposed to provide coverage for treatment for those disease states, we have both treatment and we should have insurance to cover it.

And I know that there's been some question about the extraordinary cost, but at the end of the day it's a very small segment of the population. So I've heard some numbers thrown around -- and maybe you guys -- you might not have an opinion on them, maybe you could do some research -- that it would add almost $5 to every covered insured member under a plan in the State of New York on a monthly basis. Which seems like an extraordinary amount of money for a very small segment of the population that would be eligible to use IVF.

So if you have some info around what it could potentially cost, I would really love to see it. We're still waiting for DFS to give us their report. And, you know, if

we're going to create a benefit and recommend that benefit be there to treat a medical condition, it would help if someone could give us the real cost.

MR. LINZER: And on that point, we would agree that we're interested in seeing the DFS study on this. We have seen some data on the cost impact, and I think it's consistent with what you've pointed out, Senator.

I think the thing to keep in mind, though, is while there may be a limited number of individuals who utilize the service, because of the way the insurance rules are -- I mean, those costs get spread out across the entire marketplace, so that it's not just individuals who may be utilizing those services, it's others who also pay the cost for those services. So there is a cost impact for both individuals and employers with this.

And again, I think the concern that we have with this proposal, like any mandated benefit, has to do with what the cost

implications are for employers and consumers, recognizing that affordability is the major challenge that employers and consumers face.

SENATOR SAVINO: I only have 20 seconds, but -- I understand that, but again, we're not operating in a vacuum here. The State of New York provides that coverage for its workforce.

More importantly, the City of New York does, and you're looking at 300,000 workers in the City of New York. They're not all women, they're certainly not all of childbearing age, and they're not all infertile.

But I think we have some numbers that we can extrapolate from those plans and maybe have a better idea of what it would cost if we were to spread it out.

CHAIRWOMAN KRUEGER: Thank you.

SENATOR SAVINO: Thank you.

CHAIRWOMAN WEINSTEIN: Assemblyman Cahill.

ASSEMBLYMAN CAHILL: Hi. Thanks, folks. Good to see you.

MR. LINZER: You too.

ASSEMBLYMAN CAHILL: You talked -- and I'll try to be as brief as possible. You talked about the cost of mandated benefits. In particular, you talked about the mandated benefits that were included in the budget. The Senator just talked about IVF. Are there any others in the budget that you can specify that are new, mandated benefits?

MR. LINZER: Well, the concern that we have is obviously the IVF mandate. In addition to that, there is the provision that would expand the existing mental health and substance abuse parity requirements, specifically the 14-day inpatient requirement, up to 21 days.

ASSEMBLYMAN CAHILL: So that's not a benefit, it's the configuration of an existing benefit. That doesn't create a new mandate on you to provide a benefit, it tells you that the way that the industry -- that is, the health insurance industry -- has been providing that benefit has been determined to be either inconsistent or inadequate.

Can you distinguish between new benefits that are being mandated, as opposed to the state exercising its reasonable and responsible oversight authority with health plans, to make sure that there's a consistent and fair administration of the benefits that are required by law?

MR. LINZER: So I would disagree that we do view moving from 14 to 21 days does require a new -- it is a new requirement. You know, it's extending the current mandated requirement of 14 days up to 21 days. The concern is --

ASSEMBLYMAN CAHILL: Excuse me, but that's your view. That's not the view of the federal government when they talk about mandates. That's not the view of the New York State regulators when they talk about mandates. And it's not the view of people who have done investigations of health plans to find out that sometimes one plan may do it one way and another plan may do it another way and it's not always to the benefit of the people of the State of New

York.

MR. LINZER: The way I would address this is the fact that we've moved from 14 to 21 days, there's obviously going to be a cost associated with that. So we are increasing the cost of a current mandated benefit required.

I think the other concern that we would have here is that there should be an analysis of how the 14-day inpatient requirement is working. We've pulled data to look at what behavioral health, substance abuse, opioid treatment utilization has looked like over the last four years, and what the data we've seen indicates is that we've seen a 6 percent increase in the utilization of behavioral health services, an 11 percent increase in the utilization of substance abuse and substance-dependent services, and a 46 percent increase in the use of services for opioid abuse and opioid dependence. So I think there's an expectation to look at what the service has been.

The other piece is that there's a big question of whether the 14 days is really working. And the data that we've seen has indicated that for all intents and purposes, you know, individuals are getting the 14 days, but the expectation that once they've been discharged there would be discharge planning, ensuring that there's a continuum of services across the spectrum, is not happening.

So moving from 14 to 21 days doesn't solve that problem of the opioid crisis, of making sure that once the individual has received their full 14 days that they're getting the necessary follow-up care. I think from what you'll see in our written testimony is that there really ought to be some thought given to ways to address those pieces of it because merely moving from 14 to 21 days doesn't indicate that we're going to result in better care or better outcomes for those folks, particularly individuals suffering with opioid addiction.

ASSEMBLYMAN CAHILL: I'm out of time,

but I don't disagree with you that there's a reason that there's a place for more data and more information.

But to substitute the bumper sticker for the information doesn't do anybody any good.

CHAIRWOMAN WEINSTEIN: Thank you.

Senate?

CHAIRWOMAN KRUEGER: Thank you.

Senator Seward.

SENATOR SEWARD: Yes, good to see you both again.

I wanted to return to the drug prices and the PBM proposal in the Governor's budget. Am I -- I'm correct in saying that there are contracts, negotiated contracts between your members, the health plans here in New York, and various PBMs?

MR. LINZER: That's correct.

SENATOR SEWARD: And am I also correct in saying that if in fact PBMs are having exorbitant profits that they would be, in effect -- wouldn't your members say they are being overcharged?

MR. LINZER: I think the way that -- I think our concern, you know, with this particular provision is specifically as I outlined. Regardless of how you pay, there is a negotiation between a plan and a PBM. So under the Governor's proposal prohibiting certain contracting practices, there are some plans on the market that currently have those types of arrangements; there are others that don't and actually have arrangements in place similar to what would be outlined in the Governor's budget.

Where the concern for us comes in is that the budget anticipates a savings of $86 million, and the question becomes merely moving from one payment arrangement to another doesn't necessarily translate into those costs.

We've looked at the Ohio experience of this, and while there's been a lot of attention given to the study there around the Ohio Medicaid program, one of the takeaways was that when Ohio made the change to prohibit certain contracting practices, that

their view was it would be cost-neutral, that there aren't necessarily savings by merely moving from one type of payment arrangement to another.

Here, we're not sure where -- you know, how you'd necessarily generate the savings that the Governor's budget anticipates.

SENATOR SEWARD: I guess my question is really directed at doesn't the market dictate -- provide a governor over the PBMs? Because in fact they depend on their clients, the plans, and you are looking for the lowest possible cost.

MR. LINZER: What's typically --

SENATOR SEWARD: Doesn't that hold down their exorbitant profits?

MR. LINZER: It should. I mean, these types of arrangements typically go out to procurement, there's a competitive process and, you know, PBMs and the health plans want to negotiate the best possible bargain to ensure that you get the lowest possible cost. Because at the end of the day if those costs

are too high, they translate into higher premiums.

So the short answer is yes to your question. I think the longer answer here is that there's already a lot done in the competitive process, you know, in procurement and negotiation between plans and PBMs to try and get the best possible deal. To ultimately benefit employers and consumers.

SENATOR SEWARD: Thank you.

CHAIRWOMAN KRUEGER: I think that's it. Thank you very much for your testimony.

MR. LINZER: Thank you.

CHAIRWOMAN KRUEGER: Next up, Steve Sanders, Agencies for Children's Therapy Services, again followed by American College of OB-GYNs, followed by New York State Health Facilities Association.

MR. SANDERS: Good afternoon. It's always good to be with friends and former colleagues. Actually I should say good late afternoon, early evening. Once again, you've shown amazing stamina.

I'm the executive director of the

association that provides most of the services for children in the Early Intervention Program; that's ages zero to three.

So let me just -- in the interest of time, let me cut to the chase for all of you. Early Intervention providers and agencies have not received a general rate increase in 16 years. Not surprisingly, during those years we've seen an exodus of therapists and closure of agencies that provide these critical services.

So we're grateful, very grateful that after these many, many long years the Governor has finally recommended a partial rate increase for Early Intervention agencies. He includes some of the services, not all of the services. And frankly, all of the services -- some of whom, as I say, have not received an increase in almost two decades, 16 years -- they also need and require some form of recognition, some rate increase. So we're hoping that all the services can be covered.

It's sort of like taking a car in to be serviced periodically and the dealer says, okay, we're going to change your oil and spark plugs but we're not going to look at the tires. You don't look at the whole car, you're going to have problems. So we're hoping that after 16 years this rate increase will cover all of the services in Early Intervention.

But there's a more fundamental question and issue that I want to spend a moment or two talking about, because it all comes down to money. It always does. These are budget hearings. This is all about the money, the taxpayers' money and how the state decides to spend it.

Well, for as long as the Early Intervention Program has existed, which is now about 25 years, the state and counties have been subsidizing commercial insurance. And when I say that, what I mean is that commercial insurance consistently, year after year after decade after decade, does not pay its fair share of reimbursement

for these critical services to toddlers.

It may surprise you to know that of the overall total payment, reimbursement for Early Intervention, commercial insurance pays 2 percent of the grand total. They reject about 83 percent of the claims that are submitted to it every single year. Compare that with Medicaid. Same services, same claims, Medicaid approves 74 percent of the claims that are submitted to it. The gulf is obvious.

But there's an answer, and the answer to this problem is something that the Assembly last year took up in its one-house budget bill, and that is eliminating claims going to commercial insurance altogether and, instead, substituting what we know to be called now as covered lives. Not a new program, it exists in other health insurance programs whereby you no longer -- you no longer submit claims to commercial insurance but instead you affix an assessment, what the government feels would be the proper assessment that commercial insurance ought to

be paying.

I can simply tell you this. If you affix that assessment to be only, only half of what Medicaid approves as a percentage -- only half of what Medicaid approves -- the state and counties will save about $25 million. That's $25 million that the state and counties won't have to pay because commercial insurance refuses those claims.

We know as of yesterday that every dollar, every penny is dear -- $2.3 billion additional shortfall. I'm suggesting to you a way that is good for the Early Intervention Program and will save the state and counties maybe tens of millions of dollars. I hope you'll consider it.

And I thank you for your time, as I always do.

CHAIRWOMAN KRUEGER: Thank you.

Question on the Senate side, Senator Bob Antonacci.

SENATOR ANTONACCI: Thank you, Madam Chair.

So as a county comptroller I had this

interesting conversation with my county executive at the time, and it was more towards the long-term investment. I think you're looking to just save money in the program immediately by changing some of where the cost is recovered from.

But what about the long-term investment in Early Intervention, with the payback down the road, maybe even 15 or 18 years -- lower rates of poverty, better education, crime statistics? I know it's tough to sell, you know, Give me X amount of millions of dollars today and 18 years from now I'm going to save you 25 or 30 million.

MR. SANDERS: Okay, I can address that briefly for you.

Firstly, you're from Onondaga, I believe?

SENATOR ANTONACCI: Correct.

MR. SANDERS: As you probably know, whatever commercial insurance -- or for that matter, Medicaid -- whatever insurance doesn't pay for in a given year -- I know you want the long-term answer as well. But

whatever insurance doesn't pay in a given year, your county and every county has to pay the difference, 100 percent, you get reimbursed by the state 50 percent down the road. That's millions of dollars that you ought not to be paying year after year after year.

Now, in terms of -- very good question. In terms of the investment in early --

SENATOR ANTONACCI: I said it just the way you told me to, that's why I think it was a good question.

(Laughter.)

MR. SANDERS: I had it on my notes just a little bit different, but it was close.

(Laughter.)

MR. SANDERS: All of the studies have shown -- and this won't surprise anybody, I don't think, all the studies have shown that when you remediate a child's learning problems with developmental disabilities in Early Intervention, that's ages 0 to 3, for

every dollar you invest in Early Intervention, you are saving $7 down the road. Because one of the biggest drivers in education, in the education budget, which we know is huge -- but one of the biggest drivers is special education, and before that preschool special education.

When you remediate these problems at the age of 1, 2, 3 years old, you don't need as much or any preschool special education, you don't need as much or any school-age special education, you put this child on a path to becoming a much more productive member of society and not a burden on society, because maybe of a lifetime of services that that youngster will need only because that youngster was unable to access services at the early age when the brain is able to adapt and the therapies are much more effective when you're 1, 2 and 3 years old.

So Early Intervention in the final analysis is not a cost driver, it's a cost saver.

SENATOR ANTONACCI: We ran out of

time. We could talk about this all day. I'd love to catch you another time, and please reach out to my office --

MR. SANDERS: I will reach out to your office.

SENATOR ANTONACCI: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

CHAIRWOMAN WEINSTEIN: Assemblyman Cahill.

ASSEMBLYMAN CAHILL: Good morning, good morning. I mean good night. Steve --

MR. SANDERS: That was very -- I caught that.

ASSEMBLYMAN CAHILL: Caught that?

MR. SANDERS: Yeah, I got it.

ASSEMBLYMAN CAHILL: So I know it's money that you want and you don't much care how we get it to the providers, but what the state did several years ago was they created a fiscal agent that was supposed to help facilitate -- or was sold as helping to facilitate providers in getting their money. And you mentioned that about 2 percent comes from insurers right now. And the fiscal

agent was put in place to increase that number.

So what was it when the fiscal agent started out?

MR. SANDERS: It was 2 percent.

ASSEMBLYMAN CAHILL: And how long ago was that?

MR. SANDERS: The state fiscal agent became employed in the Early Intervention system in 2013, about six years ago.

ASSEMBLYMAN CAHILL: I think we've given them about $50 million over the course of that time. And this is a private contractor that we've given $50 million to help the people that are in the industry that you represent make collections.

And have they helped?

MR. SANDERS: Well, certainly the burdens that were placed on providers and the agencies to have to be the ones that are acting as insurance collectors, submitting insurance claims and then having to collect them -- bear in mind, before 2013 the counties were doing this responsibility.

When we changed over to the fiscal agent, the state said, okay, providers, you're now going to be responsible for submitting the claims and chasing after them, but we will employ a fiscal agent to be an intermediary.

I think without personally characterizing the performance -- I like PCG, I think they try hard, but I think that the proof is in the pudding. And there has been very little change in the collection of monies from commercial insurance -- in fact, there's been no change since the state fiscal agent has been involved in this process.

ASSEMBLYMAN CAHILL: And the result is that the ranks are thinning of the people who are providing this very vulnerable service, which --

MR. SANDERS: Well, since 2013 the agencies that do insurance billing -- some providers just do the services, but then some agencies do services and also billing. The billing providers have left the system to the tune of about 25 percent because they can no longer -- they don't have the wherewithal to

do insurance and services and it's driven too many very, very good companies out of the Early Intervention area.

ASSEMBLYMAN CAHILL: Thanks, Steve. I think if we don't come together, I don't know how much longer you can carry that weight. Thanks.

MR. SANDERS: That's good (sighing).

(Laughter.)

MR. SANDERS: Very good. Thank you all very much.

CHAIRWOMAN KRUEGER: Thank you, Steve.

CHAIRWOMAN WEINSTEIN: Thank you, Steve.

CHAIRWOMAN KRUEGER: Appreciate it.

Okay, where are we? American College of Obstetricians and Gynecologists, District II, Christa Christakis, executive director.

And for people keeping track and who want to get closer, New York State Health Facilities Association next, followed by LeadingAge.

Is it evening? Not quite yet. Good afternoon.

MS. CHRISTAKIS: Thank you.

As the leading group of physicians delivering healthcare to New York's women, ACOG promotes priorities that reflect and prioritize the health needs of women across the state. And I want to thank you for the opportunity today to provide testimony on the maternal mortality prevention initiatives included in the budget.

Over the last two years, our country's high rates of maternal mortality and the stark racial disparities that exist have garnered national attention through the sharing of stories of women who have died of a pregnancy-related death. Renee Saylor, Mercedes Rivera, Kira, Yolanda, and hundreds of other women across this country -- their stories cannot be forgotten, and we owe it to them and their families to take action.

New York ranks 30th out of 50 states in our maternal death rate, and black women are nearly four times more likely to die of a pregnancy-related death than white women. ACOG has a long history of working to bring

attention to this issue, but unfortunately maternal mortality resources and prevention initiatives have been inadequate and not sustained over time. We need to make a measurable impact, and New York needs sustained investment.

This year's budget provides an opportunity for action. Specifically, the Article VII language provides for establishment of a maternal mortality review board that aligns with national best practices. It does four key things: It provides accountability and sustainability of a maternal mortality review board; it ensures the convening of a diverse multidisciplinary group of experts who serve and are representative of the diversity of women in the state; and it outlines standards to provide confidentiality protections to the board's proceedings, to allow for open and honest dialogue. And importantly, it ensures that the board will report on its findings so that we can all develop new strategies for prevention.

As was noted earlier, this language is reflective of the Maternal Mortality Task Force that the Governor established and on which I served as a member.

It's important to note that federal legislation was recently signed into law that could provide federal funds, but New York is currently ineligible for that funding because we do not have statutory protections here.

And finally, and very importantly, we ask the Legislature to ensure funding for maternal mortality prevention initiatives is included in the budget. The proposed budget includes $8 million over two years for maternal mortality prevention initiatives, including establishing a maternal mortality review board, offering implicit bias training to multidisciplinary providers, expanding access to community health workers, and building a data warehouse on maternal health to support quality improvement initiatives.

We need immediate action. New York women are counting on policy solutions to effectuate real change. And we ask the

Legislature to invest in maternal health.

SENATOR KRUEGER: Questions?

Senator Diane Savino.

SENATOR SAVINO: Thank you, Senator Krueger.

Thank you for the testimony, Ms. -- Christakis, is that how you say your last name?

MS. CHRISTAKIS: Yes.

SENATOR SAVINO: So I notice in the testimony you mention providing funding for -- insurance coverage for medically necessary abortions. You don't mention the Reproductive Health Act. And as an obstetrician/gynecologist I was curious if you had or your organization had some comments on it, because my belief is there's been a lot of misrepresentation about what the Reproductive Health Act actually does. So as a physician who practices in the field, could you speak to it?

MS. CHRISTAKIS: Sure. First I'll clarify. I am privileged to serve as the executive director of ACOG, and so I'm not a

physician. But ACOG was a strong supporter of the Reproductive Health Act, and we thank Senator Krueger, Assemblymember Glick and others for their support.

It is very unfortunate that the media and others have mischaracterized what the Reproductive Health Act does. The RHA ensures women's access to comprehensive reproductive health care. Abortion is healthcare, period. And as ACOG is an organization representing OB-GYNs who deliver quality, compassionate care to women, it is our belief that we need to ensure that women continue to have access to those services. So we were a strong supporter and continue to be.

SENATOR SAVINO: Thank you.

And again, there's been a lot of misrepresentation about it, including the idea that women cavalierly walk in at, you know, nine months and decide, I've changed my mind. And I'm hoping that, you know, ACOG going forward in the future can dispel that notion, because as you know and obstetricians

and gynecologists in the state know, that is just not true.

MS. CHRISTAKIS: Absolutely.

SENATOR SAVINO: Thank you.

SENATOR KRUEGER: I also just want to -- since Diane brought this up, I want to recognize you and your organization for being invaluable assistants and supporters in the development of the Reproductive Health Act and the materials to help educate people about what is real and what is false news.

And also to just emphasize that the decision-making in these cases will be made by doctors and patients. And that doctors are not only more than qualified to make these decisions with the women who may find themselves in difficult situations, that they also know very clearly that they must meet their licensing requirements, their Hippocratic oath, and their responsibilities to be professional doctors in the decisions they make. And I don't find anybody questioning that for every other service you provide us all the time.

So thank you. And also thank your members if they are taking any flak for simply being professionals who care about women. Thank you.

MS. CHRISTAKIS: Thank you, Senator.

SENATOR SAVINO: Thank you.

SENATOR KRUEGER: Thank you very much for your testimony tonight.

MS. CHRISTAKIS: Thank you.

CHAIRWOMAN KRUEGER: And we also next have, as I mentioned, New York State Health Facilities Association, followed by LeadingAge, followed by Primary Care Development Corporation, followed by Legal Aid Society. We'll just get everybody rolling.

And we thank everybody for their patience. It's actually -- considering we were forced out of our main hearing room, this was a very heavily scheduled hearing. Other than the comment about starting some kind of fight down there, Assemblymember.

ASSEMBLYMAN RAIA: I said cage match.

(Laughter.)

SENATOR KRUEGER: I oppose that model of fighting also.

(Laughter.)

ASSEMBLYMAN RAIA: It is legal in New York now.

SENATOR KRUEGER: We tried as long as we could to stop it.

I'm sorry, we are getting a little punchy here.

(Laughter.)

CHAIRWOMAN KRUEGER: The New York State Healthcare Facilities Association. And there are three of you, but you get five minutes in total.

MR. HANSE: We're going quick. thank you, Senator.

My name is Stephen Hanse. I serve as the president and CEO of the New York State Health Facilities Association and the New York State Center for Assisted Living. Joining me today to my right is Nancy Leveille, the executive director of our Foundation for Quality Care. To my left is Amy Kennedy, our executive director for our

Center for Assisted Living.

I'd like to thank you for this opportunity.

It's been said that to care for those who once cared for you is one of life's greatest honors. And it is with that perspective that we would like to highlight three key issues that are included in our testimony before you, briefly in our testimony. First is the significant nursing home case mix cut. Second is the desperate need for a Social Security Supplemental Income increase. And third is the healthcare workforce crisis.

You've heard a lot today on the case mix issue. It was included in the budget narrative and it was worded simply as "The state will transform the nursing home patient acuity data collection process to improve rate adequacy." What that translated to was a $246 million gross cut to nursing homes across the state, almost a third of the funds used to reimburse nursing homes.

New York has the dubious distinction

of leading the nation in the per-patient per-day shortfall at $55 a day in terms of what providers are reimbursed and the cost of care. You heard the Medicaid director earlier discuss that it's been over 11 years since nursing homes received a COLA. The state provided an increase, you heard, from the Fidelis/Centene sale of 1.5 percent. That equates to a $105 million state share per year.

The cut that the Governor proposes is a $123 million state share. So the state gave with one hand and more than took away with the other hand.

We heard from the Medicaid inspector general earlier. One of the things OMIG does is ensure that rates and Medicaid is adequately policed and no provider can receive more than a 5 percent increase, it's frozen pending an audit, so that there's protections in place.

The state's facing wholesale federal changes on the Medicare side with the turn on October 1st of this year, changing a

patient-driven payment model. The state needs to take that into account. What we would recommend is what the Department of Health initially talked about, is forming a workgroup to discuss this issue in a prospective manner, with all the stakeholders, to address case mix.

But we would urge you to reject this cut.

With that, I would turn to my colleague Amy Kennedy.

MS. KENNEDY: So as you're all well aware, throughout the state there are ACFs who take care of residents that their only source of income is SSI, the frail elderly, the mentally ill. Currently these providers are provided $41.46, with no increase in the past 10 years. That covers room, board, case management, activities.

I personally have experience as I was the executive director of McAuley, which was an assisted living program that cared for the Sisters of Mercy. Sadly, due to financial constraints, the program was closed.

This was unanimously passed by both houses last year and vetoed by the Governor. And his reason for the veto was that this was a budget process and should be discussed as a budget process, and also to work with DOH to find those funds within the budget.

I beg you to pass this again in both houses.

MS. LEVEILLE: And good afternoon. I want to talk about the health workforce crisis that we're in.

I've been a nurse for over 40 years. When I started working in the late '70s, early '80s, we had the worst crisis I had seen until now. And it's directly affecting the nursing homes and assisted living in particularly across the board.

We have a 3.7 percent unemployment rate right now, so young people have many choices to choose of where they're going to work. They only come into the health workforce if they have a true passion for that. There's many other opportunities for them. With the minimum wage increase, now

they can choose to go flip hamburgers instead of caring for some of the people that really need care.

With the minimum wage, we also have -- as we tried to raise CNA rates, but again you just heard, we're getting money and it was taken away and then additional monies to be taken. It's hard for us to increase those CNA rates. And these are the people doing the hands-on care.

If we do increase those rates, and we've been trying to increase those rates, we have wage compression with the LPNs and we have to raise the LPN rates. Well, the LPNs are now looking to go to the hospitals, they're shifting back to the hospitals. So we're losing LPNs. And the LPN rates in New York State are actually dropping. If you look at the Center for Workforce Studies, the LPN numbers that are graduating are dropping.

And so we've got a major problem here. RNs have always been a problem, especially experienced RNs in nursing homes.

So we oppose the safe staffing ratios.

We are for the study that the Governor proposes, but we also have an essential health workforce study that was outlined in April of 2018 that has a lot of good statewide regional data on nursing homes, assisted living, home care and hospitals.

SENATOR KRUEGER: Thank you very much.

Any questions?

SENATOR SAVINO: I agree with everything they said.

CHAIRWOMAN WEINSTEIN: Assemblyman Raia.

ASSEMBLYMAN RAIA: Thank you.

One of the things you didn't mention, but I'm sure it's going to have a -- has to have a major impact on you, and the commissioner really kind of skirted it when it was asked earlier, is the impact on the 14-day bed hold. You used to get money for it. Now you don't get money for it, but you still have to hold the bed.

So could you give me a guesstimate as to how much that's going to cost the industry?

MR. HANSE: Sure. Just by way of background, we used to be reimbursed at 95 percent if an individual in a nursing home had to go to a hospital and then returned to the nursing home. If you had a census in your nursing home of 95 percent or greater, you were reimbursed at 95 percent of the Medicaid rate for up to 14 days in a calendar year.

The state then went and cut that to 50 percent for that -- to save that bed for that individual if they went to a hospital and then returned to the nursing home.

The regulation that the commissioner spoke about earlier today was a proposed regulation that would eviscerate all payment, take away 50 percent, so nursing homes would receive no reimbursement, but they would be required to hold the bed in those cases. And in those cases, you have nursing homes that are very full and in population centers that people are looking to get that bed.

So on a cost basis, it's roughly about a $15 million cut to nursing homes.

ASSEMBLYMAN RAIA: Thank you.

SENATOR KRUEGER: Senator Gustavo Rivera.

SENATOR RIVERA: Hello, folks. Thank you for hanging out with us.

MR. HANSE: Thank you for staying.

SENATOR RIVERA: Yes.

So I'm sure you were paying attention closely to the -- I'm sure you were paying attention the whole day, and particularly when we were talking about the case mix issue which you discuss in your -- in your --

MS. KENNEDY: Testimony.

SENATOR RIVERA: Testimony, thank you. See, this is what happens, 9:30 a.m. to 5 p.m., words start to escape your brain. But in any event --

MR. HANSE: Wait till 9 p.m.

(Laughter.)

SENATOR RIVERA: I'll be like (gibbering).

But seriously, though, I'm sure you were paying very close attention. So there are numbers -- I'm a little bit confused with

the numbers. There was a conversation this morning in which the current Medicaid director said that the $245 million cut does not represent a third of the -- or 30 percent. Right? So if you could kind of clear that up for us.

Do you agree with her assessment or do you disagree with that assessment?

MR. HANSE: The data we have to date shows that the state spends $800 million on an annual basis, on a fiscal-year basis on case mix. They have not shared data that -- based on her numbers, she may --

SENATOR RIVERA: I'm sorry to interrupt. I'm sorry. I'm sorry to interrupt, only because I have a very short period of time. I think that she might have been referring to the -- if you're talking about the 6 billion -- she mentioned a $6 billion --

MR. HANSE: And she said $1 billion was on case mix. So it would really -- if the state -- and we haven't seen the state's numbers. If case mix is a billion, then it

would be a quarter, it would be a 25 percent cut.

SENATOR RIVERA: So it would either be 25 percent or 30 percent.

MR. HANSE: Yup.

SENATOR RIVERA: And in either case, it represents a --

MR. HANSE: It's a tremendous cut. The margin per nursing home statewide, all 629 nursing homes across the state, is 0.8. So nursing homes will go out of business. If you were to cut a third or a quarter out of the system, you would put nursing homes out of business.

SENATOR RIVERA: I'm not sure if either of you ladies want to chime in. You would have a whole minute to do so.

So anyway, okay. Thank you, Madam Chair.

SENATOR KRUEGER: Thank you. Anyone else?

CHAIRWOMAN WEINSTEIN: I think that's it.

SENATOR KRUEGER: Okay. Thank you

very much for your testimony.

LeadingAge New York. Again, followed by Primary Care Development Corporation and Legal Aid Society.

MR. CLYNE: Hi.

CHAIRWOMAN KRUEGER: Hi.

MR. CLYNE: I'm Jim Clyne, the president and CEO of LeadingAge New York. We represent over 400 not-for-profit long-term-care providers -- nursing homes, home care, assisted living, market-rate housing, HUD-subsidized housing. And we actually represent managed long-term-care plans.

We have substantial testimony there which I will not read. But I do want to point to two charts in there that show the growing crisis in long-term care. The first is on page 1. It shows the growth in population by age. The working-age population is over the next 12 years going to decrease by 4.3 percent, but the over-85 population is going to grow by 39.1 percent, leading to the obvious question of who is

going to take care of the long-term-care population.

The second chart is on page 3. It shows the extent of the cuts over the last couple of years and the cuts that are proposed now. The giant red line are the cuts that are on long-term care and managed long-term care. As you can see, they're completely disproportionate to the cuts in other portions of the Medicaid area. Not that we're asking for you to cut other areas, just showing the disproportionate nature of the cuts on long-term care.

And in particular, in the Medicaid area -- I won't be too redundant of what Stephen just testified, but the case mix cap is almost a quarter of a billion dollars coming out of the nursing home industry. This is at the same time that the state's policy is to implicitly increase the case mix.

The state is asking our members to discharge people to the community who can be discharged -- those tend to be low case mix

individuals -- and at the same time take sicker individuals from the hospitals as soon as we can. That will, in the end, raise your case mix.

Right now the Office of Medicaid Inspector General can audit anybody who has a 5 percent increase in the case mix. And in large part, they are not finding the case mixes to be fraudulent.

The other area of cuts that are substantial are the managed long-term care. There's $133 million worth of cuts, going up to $148 million in the subsequent state fiscal year. Recently two payers have closed, two managed-long-term-care payers have closed in the downstate area, including one payer that's being taken over, in which my members, all the long-term-care providers, are only going to be paid 75 percent on the dollar. So we've already provided the care. This plan is going out of business. We are not going to get reimbursed for all the costs of the care that we provided.

We also support the SSI increase. And

we really believe there is a Medicaid savings for doing that. These programs are closing all over the state. I recently had a small upstate provider shut its doors. Of the people that were still -- were Medicaid-eligible, two-thirds of them went to nursing homes. Only 3 could be placed out into the community. So rather than being taken care of at $41 a day, they're being taken care of in a nursing home at close to $100,000. It makes no sense.

Finally, we have a detailed proposal on workforce, which we'll send more information to you on. It's looking at a combination of reimbursement, directing state training dollars where the jobs are -- which is in healthcare -- and looking at ways of pulling people into the workforce and creating a message that there really is a chance for a career in long-term care.

I'd be happy to answer any questions.

CHAIRWOMAN WEINSTEIN: Jim, I actually have a question.

MR. CLYNE: Yes.

CHAIRWOMAN WEINSTEIN: And maybe it's just the late hour. Could you just explain the -- I was reading the comments about EISEP, the EISEP offset, the $15 million for EISEP, and that it results in a loss of 68 million. Can you just run through that?

MR. CLYNE: Yeah. The way we understand that -- when we first saw that, we thought that they were going to be increasing EISEP, which would then keep people out of managed long-term care. To us, that makes sense. The way we understand it now, they are increasing EISEP, but they are going to cut the managed-long-term-care providers' rates because they supposedly won't need the money to take care of the people who are going to be cared for by EISEP.

So it's not -- again, we originally thought that it made sense, if you were going to decrease the number of people coming for care, then you were going to have some savings. But a rate cut as a result of doing an EISEP increase makes no sense whatsoever.

CHAIRWOMAN WEINSTEIN: Thank you.

Anybody else? So thank you.

MR. CLYNE: Thanks.

CHAIRWOMAN WEINSTEIN: So next we have Primary Care Development Corporation, Louise Cohen, CEO; Patrick Kwan, senior director of advocacy and communications.

But I guess this is just Louise.

MS. COHEN: So thank you for the opportunity to testify in front of these committees. I will just give you the highlights of my testimony.

I'm Louise Cohen, the CEO of the Primary Care Development Corporation. We are a New York-based not-for-profit organization and a U.S. Treasury-certified community development financial institution dedicated to building equity and excellence in primary care. We provide the capital, advocacy and expertise needed to build New York's primary care infrastructure.

We're celebrating our 25th anniversary of a public-private partnership. And over the last quarter-century, thanks in part to the New York State Legislature, we have

worked with over 600 healthcare sites and seven PPSs of the DSRIP program, we have worked in enhanced healthcare facilities and practices in more than 92 percent of New York's Senate districts and 77 percent of New York's Assembly districts. And in the last five years we have provided approximately $75 million in affordable and flexible financing to expand access to primary care across New York State. We've also helped get about 500 patient-centered medical home recognitions in a variety of different kinds of primary care providers.

We've been working closely with the DOH, OMH and OASAS on the New York State Community Health Care Revolving Fund, which you made possible several years ago with a $19.5 million appropriation for our Article 28s, 31s and 32s. Since our agreement was executed in January of 2017 we have fielded inquiries of about $130 million, we have closed or are underwriting about $10 million worth of projects, and we have developed a pipeline of an additional $20 million to

projects which are slated to open soon. One is Callen-Lorde, an Article 28 in Kings County, a new 25,000-square- foot facility which will serve 15,000 patients and create a hundred full-time jobs and expand access for the LGBT communities, people living with HIV and AIDS and others who cannot otherwise afford care.

St. Joseph's Community Service Center, it's an Article 32 in Franklin County, we'll be providing much-needed substance use disorder services to rural North Country and, following our financing, a 10-bed detoxification unit, a 24/7 open access center and an expanded outpatient clinic in the Village of Saranac Lake. And we thank you for your continued support of this project.

We would like to say that we think that -- as you may have known today, there was just an announcement about the State Department of Health identified a number of organizations to get grants, capital grants through some funding that was provided

through the previous budgets. I would like to note that about half of those requests came from community-based providers. That we were given to understand there were almost 250 applications for about $824 million that was going to be allocated, but only $60 million was determined to be available for community-based providers.

And we would like you to consider the idea of perhaps, for this program, that grants paired with debt or new markets tax credits or other financial instruments leveraged through CDFIs such as ourselves and the New York State Revolving Fund would be perhaps a more effective use of capital monies going forward, because this is one way to leverage and increase the amount of money that can go out the door.

We also believe that New York should be a national leader in its commitment to funding to a strong primary care system. A number of other states have instituted measures to measure, track and increase investments in primary care, in Rhode Island,

in Oregon and now Delaware. In each one of these states there has been an increase in the supply of primary care physicians per capita without an increase in the total cost of care.

We are concerned that programs such as DSRIP, which has put an enormous amount of funding into the healthcare system, has not sufficiently invested in primary care, although there's a lot of talk about primary care. And so in the last update, about 45 percent of the total cumulative funds flow has gone to hospital systems and the PPS project officers. About -- less than 4 percent of the funds, on average, have flowed to nonhospital primary care, mental health and substance disorder treatment providers, and we think that this is something that must be changed.

We would also like -- I just would like to say that Assemblymember Raia, you asked a question about whether there was sufficient primary care providers. With your assistance, we put together this report,

which I believe all of your offices have, on the state of primary care in New York. And one thing I would point out, that there are five counties in New York State with fewer than 10 primary care providers for adults -- Cattaraugus, Hamilton, Orleans, Schoharie and Schuyler, with Wayne, Washington and Tioga not far behind.

And what we know about -- there's a correlation between the number of primary care providers per capita and premature mortality, health status, poverty and so forth. And so we think that while we know that's not a causal relationship, it is a correlation and we think that's important.

Thank you very much.

CHAIRWOMAN WEINSTEIN: Thank you.

Any questions?

CHAIRWOMAN KRUEGER: Thank you so much.

MS. COHEN: Thank you much.

CHAIRWOMAN WEINSTEIN: Next, Rebecca Antar Novick, director, Health Law Unit, Legal Aid Society.

MS. ANTAR NOVICK: Thank you for the opportunity to testify today. 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 the oldest and largest legal services organization 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 healthcare consumers. We also participate in advocacy and litigation on a variety of health law matters, with a focus on Medicaid.

New York's Medicaid recipients have endured significant changes in policies and products over the last decade. It is essential to ensure that the most vulnerable New Yorkers do not lose access to coverage and services as even more changes are implemented.

My written testimony focuses on a number of proposals that we believe could have a significant impact on our clients'

health and well-being, and I'll mention just a few here.

We strongly oppose the proposal to amend regulations to clarify circumstances in which reductions in long-term-care services may be appropriate. Current regulations provide ample flexibility for managed-care plans to reduce care if in fact that care is not medically necessary.

We represent numerous clients who are facing reductions in services or denials of requested increases. Our typical client is struggling to get by with much less care than is medically appropriate. Frequently a client's family members are forced to provide hours of informal care that interfere with their employment, their ability to care for their children, or their opportunity to get sufficient sleep.

The proposed regulatory changes would be particularly harmful to those who are unable to find an advocate or do not have family members or others to help them appeal a proposed reduction.

In stark contrast with the implication of this proposal that personal care recipients are receiving unnecessary care, in our experience some plans attempt meritless reductions for large numbers of their enrollees, with the expectation that at least some percentage of them will lack the wherewithal to challenge them.

This proposal would empower plans to propose even more care reductions. Due process rights should not be compromised in the name of flexibility.

We oppose the carve-out of transportation services from managed long-term care in the absence of provisions to better oversee transportation vendors and make sure that managed-care enrollees understand dispute-resolution options in the transportation benefit. Our clients in mainstream managed care often experience long wait times and other complications when booking rides through medical answering services. Many mainstream enrollees don't know how to complain about poor service or

challenge a denial because it's not a plan benefit.

It's crucial that MLTC members' access to transportation is preserved and that plans continue to play a role in coordinating access to the benefit even if they're not providing it directly.

The Legal Aid Society strongly supports the $2.5 million appropriation for community health advocates and urges the Legislature to provide an additional $4 million to fortify and expand this critical program. Since 2010, CHA has provided consumer assistance programs to more than 330,000 New Yorkers. CHA assists with a wide range of health insurance problems. We at Legal Aid are proud to serve as one of the specialist organizations in the CHA network providing technical assistance and training and accepting referrals of complex cases.

Over the last year, CHA has assisted Medicaid recipients with navigating the new appeal exhaustion requirements in Medicaid managed care, provided up-to-date information

to consumers concerned about the proposed public charge regulations, and provided assistance with myriad other health issues.

We oppose the proposals to increase nonprescription drug copayments in the Medicaid program and to allow the commissioner to remove drugs from the list of covered over-the-counter products without notice and comment. Even moderate increases in consumer cost-sharing can interfere with low-income individuals' ability to access benefits and services. The reality is that many of our clients cannot afford these copays and will miss out on taking needed medicine.

If a consumer cost-sharing increase goes forward, it should be accompanied by meaningful efforts to remind providers and consumers that services and benefits cannot be denied for the failure to pay a copay. Unfortunately, we do see our clients leaving the pharmacy without needed drugs when they do not have that dollar or $2 to pay a copay.

Thank you for the opportunity to

testify.

SENATOR KRUEGER: Thank you very much.

Anyone have questions? No.

Not for the -- just because of lateness of hour. Thank you.

And American Cancer Society -- and we thought we were going to have a cage fight with the American Lung Association, but I don't think they have shown up.

UNIDENTIFIED ASSEMBLYMAN: You win by default.

(Laughter; off the record.)

CHAIRWOMAN KRUEGER: Anyway, I think you're representing both tonight.

And just for people keeping track, followed by a panel of Home Care Association, Continuing Care Leadership Coalition, Consumer Directed Personal Assistance, and Center for Disability Rights. So the four other organizations can start getting closer. And we have two pages to go.

And thank you for being with us tonight.

MS. HART: Thank you. Thank you for

the opportunity to testify. I'm Julie Hart. I'm the government relations director for the American Cancer Society Cancer Action Network. We're the advocacy branch of the American Cancer Society.

You have my written testimony there where you can see the burden that cancer takes on New Yorkers. On page 1 you'll see the number, the estimate of cancer cases in New York. It's by select cancers. You can in terms of what we anticipate for 2019, breast will be the most prevalent cancer as far as diagnosis. And on page 2 you can see the number of anticipated cancer deaths that we expect for 2019, with lung cancer being the leading cancer killer, as expected, for 2019.

So I just want to touch on a couple of areas of my testimony. The first is cancer screenings. As you likely know, the state has a very good and effective cancer services program which provides free cervical, colorectal and breast cancer screening for uninsured New Yorkers.

Now, despite the fact that New York's done a terrific job of expanding coverage, there still is a very strong need for this program. It's those that -- it might be, say, a working mom, a single mom that is not Medicaid-eligible. She makes too much for Medicaid but still can't afford coverage. So this program has been very valuable. In the previous fiscal year about 26,000 New Yorkers received some sort of screening through the program.

Now, two years ago the program unfortunately was cut. It was part of that lumpen 20 percent cut. That was a $5.4 million cut, and they've had a very challenging time bouncing back. As a result, that's meant fewer screenings. So clinical services, legal services eliminated, and a reduction in survivorship programs. So we definitely urge you to try to restore that $5.4 million.

The next area that I want to touch on is tobacco control. We're very excited to see that tobacco control is definitely front

and center and viewed as a priority in this year's Executive Budget. You'll see on page 3 there's a list of proposals that we're supporting; I'm not going to go through each one. But we are very supportive and very excited to see that.

One of the issues that we do find is that people think, you know what, we've won the war on tobacco. Everybody has a story about remember when we used to be able to smoke on planes or, you know, when I first started working here you could smoke in the members lounge. And, you know, everybody has one of those stories. And even in my case, my mother smoked in the delivery room. Yeah, so that's the -- well, I'm fine, it was with my brother, so I'm good.

(Laughter.)

MS. HART: So we haven't won the war on tobacco. Fourteen percent of New Yorkers still smoke. There's huge disparities with low income, low education, mental health populations. And where we're really seeing a problem now is with kids with electronic

cigarettes. Twenty-seven percent of high school kids in New York currently use e-cigarettes. That's not just kids that have tried, these are kids that are currently using. Which undermines all of the great work that you guys have done to try to reduce smoking rates and reduce tobacco use.

We are excited to see that there is an e-cigarette tax in the budget. It's definitely needed. Nine states and D.C. currently do have an e-cigarette tax. One word of caution is we do think that as proposed it's just way too low. It's 20 percent of retail price as proposed. So if you had, say, a $10 item, you would have a $2 tax. If you think of a pack of cigarettes that might be $6 and then you have a tax of $4.35 to make that $10, there's not parity there. So we think there needs to be some parity there.

In addition, we would like to see you look at the tax on other tobacco products such as the little cigars. They might be two for $1.99, come in various flavors. Our

cigarette tax and our tax on other tobacco products have not been raised since 2010. Across the country there have been 42 different increases in cigarette taxes since that time, and 15 different increases in the tax on other tobacco products since that time. So we would definitely urge you to increase that tax on e-cigarettes and look at increasing that tax on other tobacco products as well. They are cheap, and these are the products that kids are using. And, you know, it's definitely justified. We need that to deter kids. And hopefully we can put some of that money back into cancer services and tobacco control programs.

A couple of other recommendations, but they're written in there, as you can see. That's all.

CHAIRWOMAN WEINSTEIN: Thank you.

SENATOR KRUEGER: Thank you. Questions?

CHAIRWOMAN WEINSTEIN: Thank you.

CHAIRWOMAN KRUEGER: Thank you very much. Appreciate it.

Okay. So now we have an additional panel, come on down -- Home Care Association, Continuing Care Leadership Coalition, Consumer Directed Personal Assistance Association, and the Center for Disability Rights. And each of you gets five minutes.

Good evening, everyone.

PANEL: Good evening.

CHAIRWOMAN KRUEGER: Okay, and I guess you can choose down the line one way or the other. Is this going to be a cage match also? No? Okay, thank you.

MR. CARDILLO: Thank you. Good evening, Honorable Chairs and members of the committee. I'm Al Cardillo. I'm the president and CEO of the Home Care Association of New York State. And thank you very much for this opportunity to testify today on the Executive Budget.

The Home Care Association, or HCA, is a statewide association that is comprised of all forms of home care providers and agencies in the state. We also have within our membership managed long-term-care plans,

hospices and allied organizations that support the provision of care in the home and in the community.

Just as a little table-setter, the home care system is something that the state, its policies, most importantly the constituents in this state in the health system greatly depend on for care and for the viability of the overall healthcare system. There's over 500,000 patients that are served in home care in New York State. And indeed the budget itself is also very dependent on home care, because home care has been very successful in saving monies within the Medicare program and in the public health system in New York State.

I've given you very detailed testimony. It provides information on the status of the home care system in the state and some very extensive data that demonstrates the urgent financial workforce and infrastructure support needs of home care agencies, hospices, and long-term-care plans in the state.

Just as an example of the picture of that, the data that we provide in the material, which is from the data that is presented directly to the State of New York, it indicates 74 percent of certified home health agencies are in a negative financial position. Sixty-two percent of licensed home care agencies are in a negative position. Sixty-four percent of managed long-term-care plans are in a position of negative premium. Seventy-four percent of hospices, their net patient revenue, are also in a negative position. So that data will be presented to you in greater detail in the testimony.

Our testimony also provides comments on the Executive Budget, what we support, what we would ask you to amend, and what we would ask you to insert. And of course we also include proposals that we believe could help save money within the state and improve the health system by leveraging home care and hospice.

I just want to go over those proposals in larger categories; again, the details are

in the testimony. The five categories are: To provide for sustainable financing and urgently needed support for reimbursement -- and I hope that the data that I just described is a picture of that. The second relates to modifications of the Executive Budget. The third is critical assistance with workforce shortage and support. Fourth is balanced funding for the infrastructure, and there have been comments about that today. And finally our, again, proposals to leverage savings within the system.

I'll just focus on a few highlights within each of those categories.

There is intention to provide a trend factor or some increase to hospital rates. Intended with this budget there were some increases provided in November. We certainly support the idea of hospital trend factors. But we ask you, as part of this budget, to also include home care and hospice in those trend factor increases or those rate increases.

There's language that adjusts the

methodology for home care -- continues the methodology home care reimbursement in the budget. We ask you to amend that methodology to address some of the urgent needs for rate increases for workforce, for operation, and for services.

Another important reason in that is because the rates that are used in the Medicaid system are often used as the benchmarks in Medicare. And so adjustments which would really be modest within the Medicaid program would be very, very helpful in driving a better payment scenario on the Medicare side. And when you see the data that is in our testimony, you can see the extent of the underpayment that's coming from Medicare to home care agencies.

We also ask that you look to adopt standards that across the board provide for appropriate benchmarks for home care reimbursement and that also level out, again, what are serious inequities in the payment process for home care.

We also are concerned about the

default of the healthcare plans that you heard about in this testimony, and we ask your support to hold those agencies harmless in terms of providing restitution for the gaps in their payment.

On the modification of the Executive's actions, we are very concerned about the consumer-directed plan and the fiscal intermediary proposals -- should I stop?

SENATOR KRUEGER: I'm sorry, you must.

MR. CARDILLO: Okay.

CHAIRWOMAN KRUEGER: Thank you. And of course we have the full testimony and it's published and everyone can get access to it.

MR. CARDILLO: Thank you, Senator.

CHAIRWOMAN KRUEGER: Thank you.

Good evening.

MR. AMRHEIN: So yes, I'll go second. I am Scott Amrhein, I'm president of the Continuing Care Leadership Coalition. Again, we thank you for the opportunity to testify this evening.

I certainly will submit my testimony in full for the record and just make a few

comments. CCLC represents nursing homes, not-for-profit and home care agencies. So you've heard from some of our nursing home colleagues, we just heard eloquently from Al. My testimony includes some of the same data that talks about the financial hardship that many of these organizations face around the state, which is really germane when you consider that between the 500,000 individuals who depend on home care and close to 500,000 individuals who depend on nursing home care. When you include all of the people who are coming out of the hospital and getting rehabilitative therapy, it's close to a million people in New York who really depend on these services.

And what I wanted to do is just bring a little color to amplify on the data and the statistics. You heard from Stephen Hanse that nursing homes in New York State, there's a national study, lose about $55 a day between what Medicaid pays and what the cost of care is. That's very unsustainable, obviously.

What we're seeing as a sort of a tangible consequence of that is a phenomenon where there's probably one nursing home every two months -- typically a not-for-profit nursing home -- that either closes or changes ownership. And so we're seeing a real diminution of the not-for-profit community in our state, which is concerning because there's certainly a very high, you know, kind of quality proposition in the not-for-profit sector, I'm happy to say, representing them. And just for fun, we like to look at where New York City stands in the national rankings in terms of nursing home quality, and New York does, you know, very well. It is in a very respectable place.

But if you were to take the not-for-profits, the very facilities that are being lost month after month, completely out of the mix for the metropolitan area alone, New York State would fall fully 14 places in the national rankings from where it is right now. So that's a real concern to kind of keep tabs on.

And on the home care side, I think a manifestation of the data that Al was talking about is we have the largest home care agency in New York City, VNSNY, losing tens of millions of dollars. So, you know, as an agency, the staggering size of losses that they have to deal with is very substantial. And another very large agency in the City of New York just dramatically reduced its footprint, you know, and will be able to serve -- will continue to serve patients but it will not serve as many patients in the community as it was doing previously because of these pressures.

I want to note that the state has been -- you know, you heard many people talk about the Transformation Fund. I think that investment -- it doesn't really focus on home care, hospitals and nursing homes. You know, that investment is very much welcome, but as you've heard other people say, we do not understand how in this budget there can be a proposal to take a quarter of a billion dollars out of the nursing home sector. The

goal was to try to finally, after 10 years, provide a 1.5 percent increase. This would be a 4 percent decrease. And I know there's been a lot of talk about the numbers. So the 30 percent cut or the 25 percent cut, that comes out of the aggregate of the case mix index growth. But it's a 4 percent cut out of all of the nursing home spending.

So we don't consider that to be a de minimis cut. For providers that are already losing 2.5 percent a year, that's a very substantial cut. So we strongly oppose that.

And we have in my testimony certain recommendations. As you heard Helen Schaub say from 1199 -- we feel the same way -- we don't think there's anything wrong, we fully endorse making sure that the system is watertight and people can't game the system, but the way to do that is through a workgroup and through figuring out how are you going to collect the data going forward prospectively, and start doing that. That will certainly save some money prospectively. We do not think it will be anything like $246 million.

And if you go retrospectively, that's going to be very unfair to providers and will cause a great deal of hardship.

And on the home care Medicaid rate adequacy side, I would simply endorse by association everything that Al said there. We strongly, you know, endorse those recommendations.

And I think I'll stop at that point and just leave the testimony for your perusal. Thank you very much.

SENATOR KRUEGER: Thank you. Which direction next?

MR. O'MALLEY: I'll go.

CHAIRWOMAN KRUEGER: Hi.

MR. O'MALLEY: Hello. My name is Bryan O'Malley. I am executive director of the Consumer Directed Personal Assistance Association. We represent fiscal intermediaries throughout the State of New York as well as the 70,000-plus consumers that utilize the consumer-directed program in this state.

About a month ago I was hoping to get

up here today and talk to you about the workforce crisis in the state, the low wages that continue to plague home care, in particular CDPA, and the problems we're facing with managed care. But as we noted this morning with the commissioner's testimony, those plans changed on the release of the Governor's budget.

We frankly don't understand where this attack on consumer-directed is coming from with the Governor. Consumer-directed saves the state money, it has the same or better outcomes, and it makes people happier. CDPA eliminates two of the biggest problems facing the healthcare sector today: Cultural competency and language access. If you can't -- if you speak another language, why are you going to hire somebody who doesn't speak that language? It eliminates those issues right off the top.

It is also the only thing holding together the entire home care industry today, in light of the workforce crisis that is plaguing this state. In Western New York,

consumers will literally be offered 30 hours of home care or 50 hours of consumer-directed -- not because people like consumer-directed that much more. Plans are not in the business of favoring one service over another. It's because they know they can't fill the hours with traditional home care.

You have my testimony, but I want to primarily focus of some of the points made by the department this morning. Because it seems like they're limited to three talking points, all of which are flawed.

First, the department says this is necessary because there's 600 applications for authorization that have been submitted. This was the point of authorization. The department -- we told the department in 2012, when this was moving to managed care, that there was going to be a problem, that there was going to be a large number of agencies flooding in. They chose to take no action.

In 2015, the Legislature unanimously passed licensure of fiscal intermediaries.

It was vetoed at the request of the department. Finally, in 2017, the department passed authorization as part of the budget, at the insistence of the Legislature. Two years later, in January, they finally started issuing approvals and denials in January of 2019.

We are just getting through this process now. Why are we scrapping it? This makes no sense. We agree, we fought for authorization because we want to get rid of the bad actors. We do not want people buying Bentleys on the Medicaid dollar. We want people getting services. That is what the consumer-directed program is about. We think that 600 number will get pared down through authorization. We know it will; that's the point of authorization.

However, there were LHCSA-light models before 2012. There are good programs that have come in since 2012. The Governor is taking a wrecking ball to a situation where we need a scalpel. Authorization was created to root out the bad actors. There will be

less than 600. But the fact that the Governor says there are 600 fiscal intermediaries, like this is abnormal -- there are 600 nursing homes in the state. There are -- even after the consolidation of last year, there's over 1400 LHCSAs. Six hundred is not an abnormal number.

The second misconception is that we can use less FIs because they're just payroll companies. Per the law, FIs provide more than just payroll and HR services. They provide assistance to consumers in consultation as they look to manage and become managers and run a small business in their home. They provide assistance with the recruitment process -- not in recruiting workers, but in providing matching services and other tools on how to actually go about hiring people and interviewing people. They provide -- some FIs provide peer support. Just one of my members offers a peer program, a resource library for employers on how to be a better employer, how to be a better manager.

And -- I'm done.

(Laughter.)

SENATOR KRUEGER: Perfect timing.

Thank you.

Hi.

DR. BERATAN: Hi. My name is Gregg Beratan. I'm the manager of government affairs at the Center for Disability Rights. I'm actually glad to go after Bryan, because he explained a lot of things that now I don't have to.

My concern here -- and normally I would focus on everything in the budget, but my concern here is the FI proposals.

I was interested to hear so many people talk about, you know, protecting the ACA. And myself and many other disabled New Yorkers actively participated in protecting the ACA when we, as members of National ADAPT, went down and got ourselves dragged out of hearing rooms and out of Congress and got arrested multiple times to fight the repeal-and-replace efforts. But we did that not actually to protect the ACA, I

should say; most of us were there to protect Medicaid and to protect home and community-based services like CDPA. And what we did not expect was to come home to New York and find those same services under attack from Governor Cuomo.

Now, like Bryan, I do not understand this proposal at all. It shows no understanding of what FIs do. It treats us as payroll processors and ignores the fact that we are the main service that helps disabled people with the most complex needs stay in the community. Under the per-member per-month proposal that the Governor is talking about -- and given the details that they've shared with the plans but not us -- no one can afford to support people with significant needs in the community. No FI will be able to support anyone I believe that requires more than 14 hours a week.

You know, you might be able to help the senior citizen that needs light housekeeping a few hours a week, but the vent user that requires 24 hours of support

because, you know, they need someone to be there to make sure there are no blockages, they're going to be forced into an institution. And I don't understand that because I don't understand how that saves the state money. The Governor says it saves 75 million. But forcing someone into an institution -- nursing homes, no offense, are more expensive than home and community-based services.

Nursing homes -- you know, the only way this could save the state money, and they certainly haven't said this to us, but the only way this could save the state money is if they are counting on people dying sooner because people die sooner in nursing homes. The average person dies within 19 months of entering a nursing home, or something very close to that if not less than that.

This will shorten lives, it will force people out of the community, and it's bad for the state in every way. Not only will many of the 70,000 members who rely on CDPAS for their services be forced into institutions,

but all the people that are employed supporting their needs will also be likely out of work. Because regardless of what the Governor says about this not being an attack on direct care, this will have a distinct impact on direct care. There is no way it cannot.

There are people that are accessing CDPA services now that cannot continue to do so if the support services that FIs provide are reduced to next to nothing.

Thank you.

SENATOR KRUEGER: Thank you.

Senator Rivera.

SENATOR RIVERA: So I felt that you only got through two. Now there are three. Now, if I can make sure that I got it, number one, the argument is that 600 is not a crazy number -- well, actually before that. The process was just created, we're just getting through it, so why scrap it, it makes no sense, and that 600 is not a crazy number.

MR. O'MALLEY: Mm-hmm. Mm-hmm.

SENATOR RIVERA: Number two, that the

proposal seems to suggest that FIs are strictly payroll processors, as was stated again by the gentleman at the end, and that is not the case.

MR. O'MALLEY: Correct.

SENATOR RIVERA: So you kind of left off at that moment. So if you could briefly explain a little bit more, like the gentleman did, of what it is that FIs do. And then what's your third point? Because I didn't hear it.

MR. O'MALLEY: Sure. I think the last point that I wanted to make was to what Gregg was speaking of on the per-member per-month. The department says it's going to force efficiencies. And, you know, they're saying that right now the average is $280 per member per month. They will bring it down to $100 per member per month.

I don't know where they're getting their data, because the only ones they're looking at are those that contract with managed care -- or, I'm sorry, those that are in fee-for-service. They do not have data on

managed care providers yet. They will get that this year.

From the most efficient FIs we know, their admin costs, at 12 percent of total costs, are $450 to $550 per member per month if you calculate it that way. So we're looking at an 80 percent cut, or more, to admin services. And that's not an efficiency, that's just an unprecedented cut in reimbursement.

SENATOR RIVERA: I'm sorry, I was about to sneeze there.

So just to make sure that we also get this on the record, there is -- you feel that the licensing process, which as you stated was a process that you as an organization or as an entity or certainly the folks who are involved in it believed that it was necessary to establish a licensing procedure and that such a licensing procedure -- the authorizing procedure, as you call it -- would ultimately weed out bad actors. So it's not that you don't believe the bad actors need to be taken out, but that you believe that this process,

which just started, is the way to do it.

And so kind of reiterate for me this again? So the -- it was approved in 2017 in the budget, and then the applications started going in and then the approvals only started trickling out just last month, from what you said.

MR. O'MALLEY: Correct. The applications were due December 15, 2017. So the department has had them for a year, or basically two years.

SENATOR RIVERA: So you perhaps maybe argue that we should get some money to add staff to actually process those applications and that that would probably be a more -- a better way to save money in the long term because you would actually be able to keep people in community settings and therefore not to -- is that another thing that's like -- apparently all I do is to say a couple of things and then just --

(Laughter.)

CHAIRWOMAN KRUEGER: That's not our bell, it's someone else's.

SENATOR RIVERA: It's like no, but it's like they're trying to tell me something. It's only 5:45, people. We're going to be here until 9 p.m.

The bottom line, just the bottom line -- because I'm trying to understand it as well. And it has not -- I don't know, maybe my skull is too thick. It has not cracked in there. I do not understand how something like this makes sense if we're saying that if an individual -- many of the individuals that are currently being served in this manner by Consumer Directed Personal Assistance or what have you, if they didn't have that, they would then be basically required, if they wanted to continue to live, they would have to be in a nursing home setting. Which is obviously -- and by the way, when you said "with all due respect," it wasn't disrespectful, it's just factual, right? A nursing home is much more expensive than --

DR. BERATAN: I can say much worse about nursing homes, but that's --

SENATOR RIVERA: No, you said more

expensive, and it was like no disrespect, it's more expensive. It's just factual, right, it's more --

DR. BERATAN: That's true.

SENATOR RIVERA: So I mean -- I guess I'm just stating what you said again. It just does not make sense to me in my head that something like this would actually save money in the long term. So --

MR. O'MALLEY: I would --

SENATOR RIVERA: We have only 51 seconds to make some sort of argument, because I just --

MR. O'MALLEY: I think -- look, I was going to close my remarks, if I had actually made it all the way through them, by summing up how you finished your remarks this morning to the commissioner. And pardon me, I don't speak Spanish --

SENATOR RIVERA: Los baratas son el caro.

MR. O'MALLEY: -- but sometimes the cheap is expensive. And I think this is a very clear instance where, you know, they are

trying to save 75 million and it is going to cost a lot more, both fiscally and in human lives.

SENATOR RIVERA: And the 75 million is only a calculation based on -- based on some calculation, nobody knows what --

MR. O'MALLEY: Yeah, we've asked multiple times how they got there, and they haven't told us.

SENATOR RIVERA: Okay. Thank you, Madam Chair.

CHAIRWOMAN KRUEGER: Assembly?

CHAIRWOMAN WEINSTEIN: Assemblyman Abinanti.

ASSEMBLYMAN ABINANTI: Thank you for staying so late.

And I'm not sure who answers this question, but I've tried very hard to understand what the Governor is proposing and I don't get it with respect to -- I mean, I looked at your testimony. You outlined, number one, he's trying to convert to a flat fee for FIs. Number two, he's trying to reduce the number of FIs. And number three,

he's trying to go with a statewide FI. How do you reduce the number and then go statewide? What are the -- aren't you eliminating all of the FIs if you go to a statewide one?

DR. BERATAN: There's even less to make sense of that when the -- part of the rationale they've given for where they've chosen to reduce the number is they want people who are experienced with the state or the local authorities, and almost --

ASSEMBLYMAN ABINANTI: But how does it work together? How do you get one --

DR. BERATAN: Almost any statewide entity coming in will not have experience with the entire state.

ASSEMBLYMAN ABINANTI: Is he trying to do to this system what he did to Early Intervention? Which has been very successful in driving all of the providers out and leaving people with not getting Early Intervention. So services have been cut and so have the providers.

DR. BERATAN: I can't speak to that

but I can say, as we report in our testimony, if you look at a state like Pennsylvania where they brought in a single FI from outside, it was a disaster. They had overpayments to some attendants, missed payments to some attendants, issues with hours that weren't approved.

ASSEMBLYMAN ABINANTI: But what would the other FIs do if you have a statewide FI?

MR. O'MALLEY: Well, I mean the Governor's proposal on January 1, 2020, eliminates -- closes the doors of 90 percent of FIs that day. Nine out of ten FIs in the state are eliminated that day.

And then the others will very quickly close their doors because they cannot sustain themselves on the per-member per-month formula that has been proposed.

ASSEMBLYMAN ABINANTI: Well, isn't that what they're doing over at the -- with OPWDD? Don't they pay them a flat rate?

MR. O'MALLEY: I'm not an expert on the self-direction --

ASSEMBLYMAN ABINANTI: Well, what I've

heard from those providers is that they're losing $250,000 a year on the FI function because they're banking for the state. They make the payments, they put the payments out, and then it takes them a long time to get repaid. And what -- they're limited to a certain amount of money, a minimum of $100, a maximum of -- I don't know what the maximum is. But it sounds to me like he's trying to imitate that.

DR. BERATAN: I can't speak to how they reimburse FIs, but I do know the -- how they're reimbursed in OPWDD, but I do know they get a higher reimbursement than we do.

MR. O'MALLEY: They get a higher --

ASSEMBLYMAN ABINANTI: Those are complaining that they're going out of business because they're not getting paid enough.

MR. O'MALLEY: So yeah. And I think, you know, what we can note is all of the FIs that are functional today will go out of business under this proposal. If they bring in one FI, we're going to wind up in a

situation that harms the 70,000 people using the service, harms the 100,000-plus who work in the industry, and frankly delivers critical services with all the heart and compassion of your local cable company.

ASSEMBLYMAN ABINANTI: I find myself in a strange situation because I was very concerned about consumer-directed in the first place, and I was very concerned that it wouldn't work. And now I find the Governor, after saying how great this was going to be, destroying his own plan.

And I'm really -- I don't know where to be on any of this. I'm hearing what you're saying, and I'm looking and saying, well, he hasn't replaced it with anything. He's basically destroying the plan but he hasn't replaced it with anything.

So I'm in a strange situation of defending something that I didn't think was going to work in the first place because it's better than the alternative, which is nothing.

DR. BERATAN: Well, while I don't know

what your concerns were, I can honestly say that CDPA has worked so well that it started here in New York and has traveled across the country and now is operating I believe in every state.

MR. O'MALLEY: I think it's every state, yes.

ASSEMBLYMAN ABINANTI: Okay, that's good to hear that --

DR. BERATAN: And that is something we created here in New York. We produced a document called "Early to Bed, Late to Rise," because our consumers were finding, you know, under traditional home care they had to go do bed early because that's when they could get someone in, and they had to get up late because that was the earliest time they could get in.

And this program created control for disabled people over their own lives. It has allowed more disabled people to live in the community than any other program in the state.

If this goes through, if the FIs are

limited, you might as well throw out the Olmstead Plan, because the state has given up on it completely.

SENATOR KRUEGER: Thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

CHAIRWOMAN KRUEGER: Thank you all very much for your testimony tonight.

MR. O'MALLEY: Thank you.

MR. CARDILLO: Thank you.

CHAIRWOMAN KRUEGER: Page 4, the Healthy Capital District Initiative, Kevin Jobin and John Graick, as well as the Fort Drum Regional Health Planning Organization, Erika Flint. We felt that gave us two regional mixes tonight.

Oh, there's only -- perhaps there's just one of you from Healthy Capital?

MR. JOBIN-DAVIS: Correct.

CHAIRWOMAN KRUEGER: Okay, fine. You'll just say which one you are.

MR. JOBIN-DAVIS: Absolutely.

CHAIRWOMAN KRUEGER: Or we can guess.

(Laughter.)

MR. JOBIN-DAVIS: Senators and

Assemblymembers, thank you for your endurance and your attention.

My name is Kevin Jobin-Davis. I'm the executive director of the Healthy Capital District Initiative. We have served Albany, Schenectady, Rensselaer, Saratoga, Columbia and Greene counties for 20 years now. We are a collaboration of the hospitals, health departments, federally qualified health centers, health insurers and community-based organizations from throughout the region. We provide enrollment services, school-based dental care, we lead the regional asthma coalition, and we champion regional health planning through the Population Health Improvement Program, or PHIP. We serve over 14,000 residents per year and over 600 public health professionals receive our PHIP reports and resource summaries quarterly.

The PHIP funding empowers regional, detailed examination of population health outcomes that are used by broad collaborations of public health, healthcare, community organizations and insurers to

mobilize evidence-based strategies to address leading population health concerns. They provide neutral forums for discussing, developing and implementing regional responses to public health issues. The support we provide strengthens collaborative action by using quality management techniques of establishing performance measures and shared accountability. It gives the variety of organizations involved in public health the impetus to align their investments, to improve health outcomes rather than focus only on the individuals they directly serve.

This capacity is particularly helpful in mobilizing the New York State Prevention Agenda, which doesn't have any direct funding to marshal regional action. The Prevention Agenda requires hospitals, health departments and community partners to develop aligned strategies to improve public health priorities. These organizations have different service areas, different customers they serve, and different priorities. They consist of both competitors and long-time

partners. PHIPs bring these diverse interests together in coordinated action through the development and implementation of community health improvement plans.

PHIPs similarly address cross-cutting regional issues that are prioritized by the New York State Department of Health, particularly DSRIP and the State Health Innovation Plan. In our region and some others, this takes the form of PHIPs developing training and tools to empower community health workers and care coordinators. In particular, we have researched and developed tools that enable health providers and community organizations to easily identify and refer consumers to needed services addressing social determinants of health.

These tools and training are critical resources in the evolution of healthcare from diagnosis and treatment towards helping consumers successfully complete treatment plans.

We hope that you value the work of

Population Health Improvement Programs as much as the regions we serve have, and hope that you consider them worthwhile investments in strengthening the system that supports population health in New York. And we ask for your support restoring funding.

Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Hi.

MS. FLINT: Hello. Good evening. My name is Erika Flint, and I serve as the executive director of Fort Drum Regional Health Planning Organization.

Fort Drum in Watertown, New York, is the only Army installation with a division that does not have its own hospital. And because of this military-civilian healthcare model, we exist to analyze the region, identify gaps, and ultimately leverage resources to meet those identified needs.

In 2015 we were selected by the Department of Health to serve as one of 11 regional Population Health Improvement Programs, or PHIPs, for an annual amount of

only $610,000, which translates to approximately 7.5 million across the state. And this has been eliminated by the Governor's proposed budget.

The PHIP has been a vehicle to advance the New York State Prevention Agenda in our rural corner of the state, and it serves as a platform for all healthcare transformation.

Our region relies on us for many things. We provide a neutral forum for health stakeholders to identify, share and implement best practices that enhance community health and wellness. We bring approximately 50 partners from across the healthcare continuum -- and these aren't just hospitals and primary care and behavioral health settings, but they're where people live, work and play in a prevention model: Schools, transportation centers, and beyond. And we bring them to the table to develop regional planning and coordinated efforts. We collect and we analyze data. We do this and pull it from multiple sources on a daily, on an annual, and also develop three-year

plans. These help our regions pinpoint their health disparities, identify evidence-based interventions, and arguably more importantly, course-correct as necessary.

We assist healthcare partners with health messaging and community engagement, to ensure bilateral communication with their patients and the broader community, influencing all residents, regardless of payer, to play an active role in their own healthcare.

Within my written testimony you will find stories that demonstrate where data and collaboration has led to direct improvement on the health of New York State residents and, arguably, significant cost savings.

If we allow PHIPs to be eliminated, we will be asking our communities throughout New York State to navigate without a compass, in many cases without a clear destination. Efforts to improve health and wellness will be fragmented and duplicative. They will lack directional support from data, an evidence-based resource; they will lack

community involvement and ongoing assessment. Without PHIPs, time and money will be spent inefficiently, jobs will be lost, and the improving health of our state will plateau.

As New York State utilizes the Prevention Agenda to be the healthiest state in the nation, it is the foundational investment of PHIPs that ensures we are making data-driven collaborative decisions that ultimately guarantee we are good stewards of healthcare investment.

I know you all agree with Benjamin Franklin as he has stated "An ounce of prevention is worth a pound of cure." And New York State has correctly placed an emphasis on the communities in the state in flipping the pyramid, as in time and energy and money for the betterment of the patient and the economy taking place at the lowest level of care possible. Why would the state not walk the walk, why would they eliminate a relatively small amount of funding that virtually puts the focus where it should?

I urge you to restore funding for

New York's Population Health Improvement Plan and allow us to continue as trusted stewards of this critical Department of Health initiative.

Thank you for considering this important matter.

SENATOR KRUEGER: Any questions?

I have one. Thank you both. So how does the Army get away with not providing any healthcare for their --

MS. FLINT: It's truly a win/win, ma'am. So they have -- and it has been accepted in the NDA language. So it's actually our community came to the table as a solution back in the 1980s when Fort Drum was stood up.

So where it becomes a win/win is they do primary care and ancillary services, but they don't have the hospital. So those patients receive those services in the community. We therefore are able to grow what -- in a rural area we wouldn't often need services, but because of that volume we have services and access to things that we

wouldn't otherwise. We also have TRICARE as a payer, which is reliable and a fair amount. And it allows us to provide a stable focus on healthcare and allows them to have their ability to be providing the safety for our nation.

So it truly is a win/win. It really is.

SENATOR KRUEGER: And so when Fort Drum soldiers and their families actually need hospitalization and medical care, they are paying local community providers for their service?

MS. FLINT: Yes. Yes, ma'am. They're covered by TRICARE, and that is all happening as a payer in our -- about five regional hospitals that surround the installation.

SENATOR KRUEGER: Thank you very much.

MS. FLINT: You're welcome.

CHAIRWOMAN KRUEGER: Thank you both for your testimony tonight.

MR. JOBIN-DAVIS: Thank you.

MS. FLINT: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Next up, Associated Medical Schools of New York, followed by Citizens' Committee for Children, followed by Schuyler Center for Analysis and Advocacy.

Good evening, Jo.

MS. WIEDERHORN: Hi. Thank you. Thank you very much. I'm Jo Wiederhorn. I'm the president and CEO of the Associated Medical Schools of New York.

The Associated Medical Schools of New York represents New York State's 16 medical schools. We train over 11,000 medical students over four years -- well, 11,000 students at a time, which equals over 10 percent of the country's medical students, 17 percent of the country's residents. And we have more medical schools than any other state in the country.

I'm here to talk mostly about our Diversity in Medicine program, although I do have one small thing I want to talk about before that.

One of the big things that happens at our medical schools is research into stem

cell science. This has been funded by the state for about 10 years now. We have a slight problem where the Legislature continually puts appropriations into the budget, and yet the Department of Budget puts a cash cap on it and therefore not all of the funds can go out to our researchers, which has really slowed down the amount of research and some new lifesaving cures that could come out of this research -- clinical trials, medical devices, et cetera.

Having said that, though, I would like to talk to you about our Diversity in Medicine programs, which we've been running since 1985. We have six programs right now that are currently being funded through the State Department of Health. Four of those are postbaccalaureate programs, three of those provide master's degrees. All of them, if the student successfully completes the program, there is a guaranteed admission to the medical school that sent them to that program.

We've been running those programs

since 1991. I also want to draw -- and what I'm going to talk about mainly is the funding for those programs and for our scholarship program.

I'd like to draw your attention, please, to the back of my testimony where we have our fact sheets, because I think that's more important than the narrative, to tell you the truth.

The first one looks like this. Those are our program outcomes for the academic year 2017-2018. You'll see that we have extremely high outcomes for our traditional postbacc program. At the University of Buffalo, 100 percent of the students who entered that program went on to medical school. At our three master's degree programs, 90 percent of the students that entered those programs went on to medical school.

What makes this extremely unique is that these are students who otherwise would not have been able to enter medical school. If they get accepted at any medical school

anywhere in the country, they have to go there. The intent of these programs is to increase the pipeline of underrepresented students in medical education.

This is very important because they're 31 percent of the state's population -- black/African-American, Hispanic/Latino population. Thirty-one percent of the state is made up of those two groups, where only 12 percent of the state's physicians are black/African- American or Latino/Hispanic. So we are trying to improve those percentages with these numbers.

If you go on and flip the page, the next two pages are really a summary of what our programs -- the success of our programs since 2008. As you'll see, 94 percent of the students who have entered our master's degree programs have gone on to medical school, and 93 percent of those in a more traditional postbacc program have gone on to medical school. So we have extremely high success rates in these programs.

But perhaps the most important

charts are the next two. Those are our funding charts. We start out with the bar chart, and the bar chart -- the dark amount is the amount of funding that we received. The light blue amount is the amount of students who we were able to bring into the program with that amount of funding. You'll notice that in 2017 we were cut 22.5 percent. This was when the Governor bundled services together and the Legislature was not able to restore all of those cuts. So we were cut 22.5 percent. Our funding went down to $1.244 million, which is where we are now. But the number of students have remained fairly stable.

Wow, I haven't even gotten halfway near where I wanted to. So -- that's it. The most important part is in the charts.

SENATOR KRUEGER: Thank you very much.

Any Senators, Assemblymembers?

I just want to mention that I did raise the stem funding issue with Commissioner Zucker so many hours ago, and he said he would look into it.

MS. WIEDERHORN: Thank you very much.

SENATOR KRUEGER: Thank you.

MS. WIEDERHORN: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Our next testifier tonight is Citizens' Committee for Children, unless they got on a train back to New York City. No, you hung in there with us. All right.

And I see Kate Breslin, so I know Schuyler's still here with us. And then Planned Parenthood Empire State Acts there in the back.

Okay. Hi.

MS. BUFKIN: Hello. Good evening. I'll cross out the "afternoon" on here.

Thank you for this opportunity to provide testimony today. My name is Alice Bufkin, and I am the director of policy for child and adolescent health with Citizens' Committee for Children of New York. CCC is a multi-issue children's advocacy organization dedicated to ensuring that every New York child is healthy, housed, educated and safe.

My written testimony covers a number

of issues that impact the health of children in New York, but I'll touch on a few of those in the time that I have.

First I'd like to discuss children's behavioral health services. Too many families in New York continue to experience long wait times or are forced to access emergency rooms in times of crisis. Only a fraction of children with serious emotional disturbances receive specialty mental health treatment.

As you know, New York is undergoing a significant redesign of its mental health services for children as it transitions over to Medicaid managed care. One of the transformative aspects of this transition is the introduction of six new children and family treatment and support services. These services are intended to provide family-focused community-based services that intervene early to prevent the need for more intensive services later in life.

We have a huge opportunity in our state with the introduction of these

services, and we're enormously appreciative that the Executive Budget includes $10.5 million to reimburse providers for the provision of these services. However, we do feel there are some additional steps the state can take to ensure the success of Medicaid redesign.

First, we urge the Legislature to provide an additional six months of enhanced reimbursement rates for CFTS services. Currently providers are receiving the enhanced rate during the first six months as these services are being introduced. This is really around ramp-up and really doing the outreach for communities and families to make sure that they know what services are being provided, making sure that providers are able to offer the services, really during that sort of initial period that's needed as we introduce these really sort of transformative new services in the state.

However, a number of different challenges in the state, including some of the timeline changes that have come down from

CMS, have made it clear that we do need an additional extension of that enhanced reimbursement rate period.

Additionally, because of how valuable these services are, we believe they should be made available not just to children on Medicaid but also to children in Child Health Plus.

I next want to turn to Early Intervention, and was really appreciative of the conversation that happened earlier today, both about the importance of Early Intervention and some of the challenges that it's facing.

As you know, EI provides evaluations and services to children age birth to 3 with developmental delays and disabilities. Professionals work as a team with families to address the unique needs of each child. Intervening in the first years of life can change a child's developmental trajectory. It can lead to positive long-term outcomes across health, language and communication and social and emotional domains.

Despite the critical role that Early Intervention plays in the lives of young children, as you've heard earlier, New York cut the EI service rate for home and community-based services by 10 percent in 2011, and cut the rate for all EI services by an additional 5 percent in 2011. This rate has remained unchanged since that period; it's actually lower than it was 20 years ago.

As a result of rate cuts and changes to reimbursement processes, we've seen providers throughout the state forced to close their doors or stop providing EI services. For example, there have been stories out of Monroe County about children being on a wait list for evaluations. In New York we saw one of the biggest providers of EI have to close its doors because it was no longer able to continue providing services.

Provider shortages and wait lists mean children who are desperately in need of services are forced to wait during a period when those services would be most beneficial

and have the biggest influence.

For this reason, we're enormously appreciative of the inclusion in the Executive Budget of a 5 percent increase for occupational therapy, physical therapy and speech language pathology. We feel this is an important first step towards getting back to where we need to be.

I would echo the recommendation you heard earlier, though. We would like to ensure that the 5 percent restoration applies to all EI providers, evaluators and service coordinators. Failing to extend the 5 percent rate to all providers may drive some out of the field, further increasing shortages.

And we also recommend increasing reimbursement from private health insurance companies by supporting a covered lives proposal, which I know has been championed by several on this committee. This proposal would assess a fee on insurance companies to help cover the cost of EI services, instead of asking private insurance companies to

review each claim for EI services.

Next I want to touch briefly on a couple of items related to public health. We strongly oppose the Executive Budget proposal to reduce the reimbursement to New York City for its General Public Health Work program. This program funds health initiatives that are the foundation of New York City's public health infrastructure, including programs like Nurse Family Partnership, the Newborn Home Visiting programs, child health clinics, immunizations, grants to look at lead inspections. We'd certainly appreciate more funding to other counties, but unfortunately this is only taking funding away from New York City.

We also want to express our support for initiatives to improve maternal health outcomes and reduce childhood exposure to lead. Because of how critical these issues are, we want to make sure there's sufficient funding and also that the burden isn't fully falling on counties.

And finally, in the last few moments,

I want to express our support for increasing comprehensive coverage options to more New Yorkers, as well as increasing funding for health navigators so more families can have access to services.

Thank you again for your time.

SENATOR KRUEGER: Wow. That was solid. You did it. You did it.

Any Senators? We're just impressed with your timing.

MS. BUFKIN: Thank you very much.

CHAIRWOMAN WEINSTEIN: Assemblyman Abinanti for a question.

ASSEMBLYMAN ABINANTI: Thank you for your presentation. Just a couple of things.

I think I asked one of the commissioners this morning, gee, there's a wait list for Early Intervention, and she kind of scoffed at that, as if there was none. But you and I are both on the ground and we're finding that it's taking longer and longer for kids to get early intervention services.

MS. BUFKIN: Yes. And, you know, as

you know, we're talking about children who are getting services age birth to 3, so their window for actually receiving services is so small. So when we see delays of even a few months, that means children aren't getting into services at those really critical times when they need them.

ASSEMBLYMAN ABINANTI: One of the things that I've heard about is they take kids off the list once they get one of the services which they're designated for, and so the list is not really current. So if a child needs speech and behavioral and OT, they'll get speech and then they'll say, well, we've given the kid services -- so therefore no longer on the wait list, it makes their numbers look better.

MS. BUFKIN: Hmm. You know, I hadn't actually heard that, but I would be happy to reach out to you afterwards and we can talk to our partners, because we work with Winning Beginning New York and a number of other coalitions. We can check in on that and get back to you on --

ASSEMBLYMAN ABINANTI: Have we reduced the number of EI providers?

MS. BUFKIN: So I haven't seen the full number, but I know that there have been -- yeah, I mean, there have been providers who needed to drop out because, as I mentioned, in Monroe County and Franklin County and New York City we've seen providers drop out because they just aren't sustainable.

ASSEMBLYMAN ABINANTI: Yeah, I know I spoke with a provider this week who was saying that they're losing a ton of money on Early Intervention and they can't really continue or expand, and they know there's lots of kids out there that need it.

What's the impact of managed care on this whole picture? I'm not going to go through item by item. But we're pushing kids into managed care. What's the impact?

MS. BUFKIN: I don't know if I'd be able to speak entirely to that. I mean, I think, you know, ultimately our goal in however services are being delivered is

making sure that we're not limiting the types of services that children need, that the number-one focus is on making sure that each child has developed for their unique needs and they're getting a comprehensive evaluation and they're getting a comprehensive set of services.

So, you know, I think that that's our main priority is in the system as it is now, making sure that that's the services they're getting.

ASSEMBLYMAN ABINANTI: Okay. Thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

SENATOR KRUEGER: Thank you very much for your testimony tonight. Appreciate it.

Schuyler Center for Analysis and Advocacy, followed by Planned Parenthood, followed by Sickle Cell Thalassemia Patients Network.

Hi. How are you, Kate?

MS. BRESLIN: Hi. Thank you.

My name is Kate Breslin. I'm the president and CEO of the Schuyler Center for

Analysis and Advocacy. And my colleague Alice Bufkin totally, you know, shaved off some of the time that I'm going to need.

We're a statewide nonprofit organization. We've been around since 1872. And our focus is shaping policy that affects the most vulnerable New Yorkers. We're part of the leadership team and the administrative home for Medicaid Matters New York, and we're involved with many of the other consumer-oriented health coalitions. And I've been really privileged to lead the First 1000 Days on Medicaid, Value-Based Payment for Children and Adolescents, and other Medicaid initiatives.

Our focus is on ensuring healthy development for all children and understanding that children's healthy development depends to a large extent on the health and well-being of their caregivers. So I just want to make sure that we're thinking about that as well.

I want to mention that last year saw the nation's first increase in the number of

uninsured children in nearly a decade. And New York wasn't immune to this trend. So looking at 2016 data, we started to see an increase in the number of uninsured children after a decade of decline. And considering some of the proposals that have been coming out of the federal government, we are likely to continue to see that concerning piece of data. And that's happening despite our economic recovery. So I just want to make sure that we're mindful about that.

What I thought I'd do is focus on some of our overarching concerns. You will read those in the testimony, but I want to just call out that some of the things that I would like to ask you to think about as you review the budget are shifting costs to localities or putting new demands on localities without the resources to back them up -- investing in sometimes worthy causes and then pulling funding from other important areas, and disinvestment in public health and health planning at the very same time we're talking about the importance of social determinants

of health.

And then specifically what I'd like to call out is our support for the focus on maternal morbidity and mortality. We hope that that will include a focus on maternal mental health, which is something that we've been focused on a lot and that is really important when we think about maternal health. And that we're really supportive of making sure that there's investment in maternal morbidity and mortality, and particularly looking at disparities. We want to make sure that the funding for that doesn't get stripped from other important public health activities that are happening in the Department of Health.

I'll really just reinforce what Alice and Steve Sanders said earlier about Early Intervention. It's a real problem. It's so important that in that age, that early period zero to three, that we support young children. We miss this fantastic opportunity to mitigate or even eliminate delays and disabilities in that period to our peril

later in our school system and in all of our other systems.

And so we're excited that the Governor put in a 5 percent increase in Early Intervention rates after many, many years of no cost increase that were preceded by a cut for certain providers in the Early Intervention program. We too would like to see that extended to all providers and service coordinators in EI. We too are hearing the same things that our colleagues are hearing, that we are -- the kids are waiting and that we're losing providers.

And then I'd also like to call out the importance of maternal, infant, early childhood home visiting. We hear a lot of talk about it. We know that many of you support it. But we haven't seen a significant funding increase for maternal, infant and early childhood home visiting in quite a while.

And then finally something that you'll see in my testimony is about the 2020 Census. And the reason I'm calling it out in our

health testimony is because New York has not yet invested in making sure that we have an accurate count. We are at risk of having an inaccurate count particularly because of our high immigrant population, our densely populated cities, as well as we are facing a severe undercount of very young children.

And that will drive the funding that we get from the federal government for years to come. As you know, it will also drive the power that we get at the federal level for years to come.

So I'm mentioning it here now because I really want to make sure that we are focused on funding an accurate count.

SENATOR KRUEGER: Thank you.

Any Senators? Assemblymember?

ASSEMBLYMAN ABINANTI: I'll be very brief.

CHAIRWOMAN WEINSTEIN: Assemblyman Abinanti.

ASSEMBLYMAN ABINANTI: Are you competent to talk about what's happening to center-based Early Intervention? I'm

understanding that those center bases are going out of business because there was something in the funding formula which is discouraging center-based Early Intervention. Can you talk about that?

MS. BRESLIN: I can't get into any depth on that. But I imagine my predecessor -- one of our previous speakers, Steve Sanders, probably -- he works with those providers.

ASSEMBLYMAN ABINANTI: But you've heard about that?

MS. BRESLIN: What I've heard from people in communities is that kids are waiting a long time to get evaluated and often to get services in some communities. And that providers are leaving the field because they can't afford it.

ASSEMBLYMAN ABINANTI: Okay. Because I've heard also that center-based Early Intervention is really nonexistent in many places. And for some kids, to get them out of the household into a center, where they can socialize with other kids and parents can

meet other parents, et cetera, is just not able anymore, not happening anymore.

The other issue, very quickly, was you talk about health insurance parity. I raised an issue with one of the -- with the Medicaid director this morning about insurance companies not providing coverage for different types of care, specifically in the behavioral health area, where they say we're not going to cover behavioral health, we're only going to cover mental health. And they're not doing it -- well, they'll do it only in New York, not out of state. Have you come across that at all?

MS. BRESLIN: Well, I will say that one of our recommendations, similar to what Alice said earlier, is that specifically within the Early Intervention Program, that we find a way to make sure that our health insurance companies are paying their fair share and not -- not not doing that.

ASSEMBLYMAN ABINANTI: Okay. Thank you.

SENATOR KRUEGER: Thank you very much

for staying all day. And tell your father we noticed he wasn't here.

(Laughter.)

CHAIRWOMAN KRUEGER: Oh, dear, I just said that on open mike, didn't I? Yes indeed. Take that off the transcript.

(Laughter.)

CHAIRWOMAN KRUEGER: I'm sorry. Always up for a good time.

Robin Chappelle, of Planned Parenthood.

MS. CHAPPELLE GOLSTON: Thank you. Thank you so much for giving me the opportunity to give testimony today -- this evening. I will keep it very brief.

My name is Robin Chappelle Golston. I am the president and CEO of Planned Parenthood Empire State Acts. We represent nine affiliates statewide who provide primary and preventive sexual health and reproductive healthcare services to over 186,000 New Yorkers each year.

We are truly in challenging times, needless to say. It seems daily we are

witnessing unrelenting and unprecedented federal attacks on our basic and most fundamental rights. These policies and actions are damaging the fabric of our communities, threatening the health and well-being of far too many, and taking us further from a vision of equality for all.

New York, however, has responded and been swift about it. After nearly 12 years of political obstructionism, we want to thank you for passing the Reproductive Health Act and the Comprehensive Contraception Coverage Act. Thank you so much for the support.

I would also like to elevate the funding for the state Family Planning Grant. For decades the state has wisely invested in the Family Planning Grant, an essential program that supports delivery of high-quality patient-centered preventative reproductive sexual healthcare for low-income, uninsured and underinsured individuals who may otherwise lack access to care.

Core services provided include

wellness exams, cervical and breast cancer screenings, birth control, contraception education, testing and treatment for sexually transmitted diseases, and HIV testing. Grant funding enables services to be provided on a sliding fee scale so that cost may never be a barrier to one's ability to obtain care. In 2017, over 300,000 individuals received Family Planning Grant services from 48 agencies operating in 173 sites. In New York, 2/3 of those patients who received care at Family Planning Grant-funded agencies have incomes at below 100 percent of the federal poverty level.

Every year the state reaffirms its commitment to the grant through the budget process. However, despite rising costs of delivery of care this funding has remained flat. And it actually received a 5 percent decrease in 2013. Last year the cost-of-living adjustment, the COLA, for public health grants like the Family Planning Grant was eliminated.

In short, grantees are expected year

after year to meet the needs that exist in these communities across the state with less funds.

These challenges are increased by the threats being waged against reproductive healthcare at the federal level. For nearly 50 years, the Title X program has provided birth control and other preventative healthcare to millions of low-income people, and federal Title X funds comprise approximately 19 percent of the New York family planning grant.

And those funds are now at risk. The Trump-Pence administration has published a proposed gag rule that would fundamentally undermine this critical program.

While we want for federal action on Title X, we respectfully request the Legislature advance, in their houses, a $2 million add to the Family Planning Grant to address years of stagnant funding for this important program.

We also urge the Legislature to advance both the funding and policy language

that establishes a Maternal Mortality and Morbidity Review Board and that is aligned with best practices.

We thank you for your time today and look forward to working with the Legislature in shaping the final budget.

SENATOR KRUEGER: Thank you. Any Senate questions?

I just have one Senate question. Thank you for all your work.

But specifically around adolescent pregnancy prevention funding, which also provides training to protect against bullying and sexual harassment and decreasing numbers on sexually transmitted diseases and unwanted pregnancies. Is there some data confirming that an investment in this program actually decreases the costs on all those other things I just listed?

MS. CHAPPELLE GOLSTON: Sure. I mean, you know, addressing those issues head-on definitely makes a difference and lowers costs, especially in regards to even going to problems that can arise in STI treatment and

learning to make the best choices in their lives at an early age is really fundamental to making sure that those costs don't multiple later on. So it definitely makes a difference.

CHAIRWOMAN KRUEGER: Thank you.

Assembly?

CHAIRWOMAN WEINSTEIN: Assemblyman Cahill.

ASSEMBLYMAN CAHILL: Robin, I thought it was important enough to talk to you that I made Helene Weinstein and Will Barclay mad at me to do so.

MS. CHAPPELLE GOLSTON: Sorry.

ASSEMBLYMAN CAHILL: No, I just wanted to know how Planned Parenthood is faring with being a target by the federal government and with all the cuts that you're enduring. And what are some of the practical things that you have been forced to do as an organization in order to continue to provide adequate services to the people of New York State?

MS. CHAPPELLE GOLSTON: Sure. And fortunately, we have a lot of support from

New York State, so that has definitely been a buffer up until this point. But like I said earlier, there's needless attacks on a federal level that continue on every level, especially even from the tax for -- the passage of RHA has been very problematic, and the Title X gag rule is going to be really problematic for funding, and have an impact on the state as well.

You know, we keep fighting forward, we keep serving our patients, and we're going to do what we need to do. But it's definitely been a heavy burden and definitely taken us away from providing for our patients.

ASSEMBLYMAN CAHILL: Well, thank you for everything that you do. And I hope that my colleagues and I can demonstrate to you and to your colleagues that we appreciate the things that you do for the people of New York, from the bottom of our hearts.

MS. CHAPPELLE GOLSTON: Thank you. And thank you for your leadership on CCCA.

SENATOR KRUEGER: Thank you so much for your time tonight.

MS. CHAPPELLE GOLSTON: Thank you.

CHAIRWOMAN KRUEGER: Our next testifier is a group of people from the Sickle Cell Patients Network. And I believe it's Thomas Moulton, Doris Polanco, Cheryl Cannon. It's one group, five minutes, but three people.

DR. MOULTON: We had another person, Demitra, who's a young Greek woman with sickle cell disease, but because of her illness, she couldn't be here. But you should have her testimony at least later from us.

CHAIRWOMAN KRUEGER: Thank you.

DR. MOULTON: And it is Sickle Cell Thalassemia Patients Network.

CHAIRWOMAN KRUEGER: Thank you. I didn't want to make a mistake twice, so I skipped the important word, so I apologize.

DR. MOULTON: So good evening, everyone. As mentioned, I am Dr. Moulton. I am a pediatric hematologist-oncologist, and I work with the Sickle Cell Thalassemia Patients Network. And I thank you all for

allowing us to testify before you. And I'm here to discuss hopefully an increase in adequate funding for sickle cell disease and sickle cell trait in New York State, and to support the statewide sickle cell programs.

New York State is the most populous state with sickle cell disease, having 10 percent of the nation's population. The births in New York State show that while in the nation, one in 365 African-American births have sickle cell disease, in New York State one in 230 have sickle cell disease. For Hispanics, one in 16,300 nationally, but one in 2,320 in New York State. In Caucasians, one in 80,000 nationally but one in 41,647 in New York State. You can see the increased numbers in New York State.

There are approximately 100,000 patients with sickle cell disease in New York State and 3 million with sickle cell trait. That's 100,000 with sickle cell disease.

So what is sickle cell disease? Sickle cell disease is an inherited disease where one parent has sickle cell trait, but

one parent can have one of four other hemoglobin variants. So a person can have other traits and still have a child with sickle cell disease.

So in my practice -- and I've had 30 years with sickle cell care -- a mother comes in, "I can't have a child with sickle cell disease, my OB tested me, I don't have sickle cell trait." But she has beta thalassemia 0 and, combined with her husband's sickle cell trait, that made their child have S beta 0 thal and actually have sickle cell disease.

Another child of three years of age, hospitalized for pneumonia, highly suspected the child had sickle cell disease, mom said, "My child has sickle cell trait." Tested the child, the child had actually SC type of disease. The physician told the mother she had trait because she had only one S gene and did not realize that the combination was actually disease and not trait.

This is some of the misinformation that's out there.

So in sickle cell disease there is an abnormal hemoglobin, and hemoglobin is the protein that carries oxygen in the red blood cells to all parts of the body. And under certain conditions, those red blood cells will change shape. They're normally a donut shape, but then they will change to a sickle cell shape. And these sickle cells then clog the small and medium blood vessels.

With that clog, the oxygen is deprived to the cells beyond the clog and the pain in sickle cell disease is caused by these cells screaming as they die from the lack of oxygen.

SENATOR KRUEGER: Doctor, I only just want to point out you have two minutes left for everybody. And we want to make sure you get to why you're here.

DR. MOULTON: Oh, it's five for everybody.

CHAIRWOMAN KRUEGER: Five total.

DR. MOULTON: Oh, it's not five apiece.

SENATOR KRUEGER: No, sir, no.

DR. MOULTON: Then I will accede to our patients, for them. I thought it was five per person, but no.

MS. POLANCO: Hello. My name is Doris Polanco, and I have sickle cell SC. And the person you're seeing today in front of you, I'm actually here because I got a transfusion three days ago and if it weren't for that, I'd be at home, zombie mom, drowsy from so many medications.

So first I want to say that it's very hard to find a blood that's matched for me because of my antibodies that I've developed from so many different blood transfusions throughout my life has made it very difficult. Sometimes I get scared that, you know, in the moment of an emergency there's not going to be blood out there that's going to match my antibodies and I'm scared I'm not going to survive and I will not be here for my daughters tomorrow.

MS. CANNON: My name is Cheryl Cannon, and I've been advocating to improve care for sickle cell patients for over 30 years,

beginning with the birth of my son, who was born with sickle cell disease and had a stroke at age 3.

On December 5, 2017, my son died due to acute complications attributed to having sickle cell disease. My son was only 34 years old. He was a devoted husband and father. He left behind a wife and a 5-year-old daughter who will not know what it's like to have a father.

And I'm here to urge you to fund in this budget -- to put in funding for the sickle cell bill. We have a sickle cell bill that has to be reintroduced into the Legislature.

MS. POLANCO: And I just want to say one thing. Sickle cell is not a black disease like a lot of people think. That is a misconception. So I just want to put that out there.

SENATOR KRUEGER: Thank you.

Senator Rivera has a question.

SENATOR RIVERA: Yeah. First of all, thank you all for hanging with us.

MS. POLANCO: We've met you before.

SENATOR RIVERA: Yes, you came to my office.

DR. MOULTON: Yes.

SENATOR RIVERA: So thank you for hanging out with us.

Two things, one for you folks, probably most for the doctor but certainly the two ladies can chime in. First of all for the doctor. So I'm looking at the rates here of one through 365 for black folks, one to 230 in New York State, and the numbers that you mentioned at the beginning of your presentation. Why in New York? Has there been something that has helped us establish why this happens in New York across ethnic lines like this, when the numbers are so disparate from the rest of the country?

DR. MOULTON: When you look at it, approximately 80 percent of those sickle cell disease patients in New York State are residing in the New York City area. And when you look at who comprises it, it's the melting pot of the world. Right? And so

there are a lot of immigrants.

And the reason why Hispanics are so high is because of the number of Caribbean Hispanics that are in New York City. And the slave trade moved into the Caribbean, it did not move into Mexico. The Mexicans were the slaves for the conquerors there, they didn't need to import slaves. So when you think of Puerto Ricans, you think of the Dominican Republic, you know, all those communities that are here in New York City.

So there's a large immigrant population that's here as well as, you know, a large African-American population.

SENATOR RIVERA: Gotcha. Since you have a minute 30, I just want to make sure that you state for the record the ask that you're making of us for this budget, please.

DR. MOULTON: There's been various things. We would probably ask in terms for $5 million in terms for setting up specific centers throughout the state that would address these issues and a coordinating center.

SENATOR RIVERA: What's currently in the budget?

DR. MOULTON: Zero.

SENATOR RIVERA: Was that the case last year?

DR. MOULTON: Last year we had 170,000. There's been a 66 percent decrease in the last 20 years in funding. With no funding this year, that will be a hundred percent decrease in funding.

MS. POLANCO: And --

SENATOR RIVERA: Go ahead, ma'am. You have a minute.

MS. POLANCO: I just want to say because of that decrease in funding, I've lost personally three friends in the past four months because of sickle cell, and I -- right now we're all scared because the group of friends that I have in my clinic, because we all have similar sickle cell lives, you would say, you know, in terms of the medications we take and the type of symptoms we all have. And it's like, you know, am I going to be next?

And it's just like it's hard finding high-quality care for sickle cell patients all across.

SENATOR RIVERA: And this $5 million would make that easier.

MS. POLANCO: It would certainly help.

SENATOR RIVERA: It will help make that easier.

MS. POLANCO: It will get the ball rolling.

MS. CANNON: And we see the life expectancy in sickle cell adults decreasing. I've known at least three males in their 30s that have died in 2018 from sickle cell disease.

SENATOR RIVERA: Thank you so much for staying with us.

SENATOR KRUEGER: Thank you very much for being with us and staying. Thank you.

SENATOR ANTONACCI: Can I just ask one question, Chair? I'm sorry.

CHAIRWOMAN KRUEGER: Oh, I'm sorry.

SENATOR ANTONACCI: That's all right. I'll be real quick.

I saw -- maybe I read this right -- the average cost per case is about a million dollars? Did I read that right?

DR. MOULTON: Up until about age 45.

SENATOR ANTONACCI: So most private insurance carriers probably have a cap of about a million dollars? You see a lot of patients reaching the cap?

DR. MOULTON: Well, the majority of patients, because of the debilitation of their disease -- silent strokes, other sorts of things -- are actually on Medicaid. Probably 50, 70, 80 percent of patients are on Medicaid. It is the most costly disease per patient for Medicaid, costing 50 percent more than HIV.

And yet -- and when you look at, in New York State we looked at 2004 to 2008 in terms of trying to count the patients. There were only 14 percent of the patients who were older than age 50. That tells you how quickly they die. For HIV, their life span, a 20-year-old from 2008 on can live to 78.

SENATOR ANTONACCI: Thank you.

SENATOR KRUEGER: Thank you very much.

MS. POLANCO: I just want to say I have a newfound respect for you guys just because you're here all day.

(Laughter.)

SENATOR KRUEGER: Thank you. And you were here all day watching us, so thank you to you also.

DR. MOULTON: Thank you for listening.

MS. CANNON: Thank you.

CHAIRWOMAN KRUEGER: Okay, our next testifier -- actually, Alternatives for Children, is someone here still? Hello. And then afterwards Autism Speaks. Oh, they are a panel. Hello. Excuse me.

Thank you, Senator, that's good. You start to get this brain fog after a while.

I apologize, ladies. Five minutes for each of them for the clock, gentlemen.

Hi.

MS. O'GRADY: Hi. My name is Maureen O'Grady. I'm a board-certified behavior analyst and a New York State-licensed behavior analyst, and I'm the associate

director of the Autism Program at New Alternatives for Children, also known as NAC. NAC is a child welfare agency in New York City that specializes in treating children who have complex medical and behavioral needs.

The only reason I have the opportunity to be employed by a child welfare agency is because of an Autism Social Skills Grant which covers service for 25 children. Otherwise I would not have contact with this system because I provide applied behavior analysis, ABA therapy, which is not covered by Medicaid.

At our agency alone, we have 164 children and young adults with autism under the age of 21. Ninety-five percent of these children have Medicaid. Many of these children have experienced fragmented health services, trauma, abuse and/or medical and educational neglect. Nearly 40 percent of these children are nonverbal, and at least 50 percent of them engage in aggressive or self-injurious behavior. These behaviors

make them more likely to be in restrictive settings which may negatively impact their social functioning.

I receive weekly requests from prevention and foster care staff for consultations about problem behavior with our autism clients. Seventy-five percent of those referrals are for children who are over the age of 5. Some of them are in their teens. And they're not toilet-trained, they do not have a form of functional communication, they may engage in self-injurious or aggressive behavior.

Some of these clients received ABA services through EI, but because they have Medicaid we're not able to access ABA services after that.

In 2017 I received a referral for a 6-year-old male to join the social skills group. When I assessed him, I realized that the social skills group would not be an appropriate placement for him. He is nonverbal, he is self-injurious, he hits his head on hard surfaces, scratches his skin to

the point of bleeding, and consistently bangs his body against walls. He's also aggressive, he hits, kicks, bites and scratches adults and peers.

After consulting with his psychiatrist and his caseworkers, we decided to give him a one-on-one ABA session instead of enrolling him in the group.

I've worked with this child since April of 2017 for one hour a week in our clinic. I introduced a simple communication board consisting of six items that were highly motivating for him in order to get him to communicate. Currently he is requesting two of those pictures -- not all six, but two of them -- with 60 percent accuracy. Hitting staff has decreased by 28 percent and identification of colors in an array of two has increased by 20 percent.

Although we've had some successes with this client, the frequency of service is much lower than what would typically be recommended for a child of his age and abilities. This child is now 8 years old.

He remains nonverbal. He is not toilet-trained. And he still engages in a significant amount of aggression and self-injury. It is clear that this child needed continued services after EI but was unable to access them.

In contrast, I work privately with a family in New York City who's able to access their ABA services through insurance. This child started services in 2017 at the age of 3 years old at 10 hours a week. This child received EI services. This child was also not toilet-trained, was also nonverbal and is also -- was also self-injurious. Today, at age 5, this child has increased independent requesting by 90 percent using an iPad communication system with 20 pictures. She's making 15 word approximations per second and has reduced her self-injurious behavior by 65 percent. She's also fully toilet-trained.

The difference between these two children is absolutely heartbreaking. This is just one example of the 164 children we have at our agency who need this service.

The children of New York who have Medicaid deserve equal access to these services at a frequency that is medically necessary for their overall improvement.

Thank you for listening.

SENATOR KRUEGER: Thank you.

MS. URSITTI: Hi. I'm Judith Ursitti, director of state government affairs for Autism Speaks. Autism Speaks is a leading autism advocacy and research organization. We work a lot on awareness too. We've been active across the country from an advocacy perspective specific to healthcare coverage for autism spectrum disorder across the life span.

We worked very hard here in New York State with many of you to pass a private health insurance coverage requirement back in 2011, and we're profoundly grateful this session to have funding included in the Executive Budget specific to Medicaid coverage for this same treatment.

This is a long time coming in New York State. If you look in the handout that we

provided, there's a map on the back that shows 40 states that have moved forward with Medicaid coverage for autism spectrum disorder. This is subsequent to a requirement, a bulletin that was put forth by CMS in 2014. In 2014 CMS said to the states that under a provision called EPSDT, early periodic screening diagnostic and treatment, that children with autism should receive medically necessary care across the country, and they urged the states to move forward.

So as you can see on the map, many, many states have. I've had the privilege of working in states like Georgia, Massachusetts, North Dakota, now Oklahoma and Texas, New Jersey, Connecticut, Vermont -- a diverse group of states moving forward just to make sure that children who are Medicaid-enrolled have access to just basic evidence-based care for autism spectrum disorder.

It's important to note that the information that was included in the Executive Budget was a little fuzzy. It's

critical that when we think about EPSDT and the federal statute that we think about it requires coverage for under the age of 21, zero to 21, without any restrictions around age. So we ask that as you move forward with budget negotiations that you make sure that you come into compliance with that CMS requirement and that the coverage under Medicaid is for children under the age of 21 completely.

And with that, I will finalize my testimony. Thank you so much for all your attention today.

SENATOR KRUEGER: Senator Antonacci.

SENATOR ANTONACCI: Thank you, Madam Chair.

So you're okay with the Governor's budget but you don't think the language is clear enough, you want to make sure we're covering all children under the age of 4?

MS. URSITTI: No, actually the CMS requirement, the bulletin, is for coverage for children under the age of 21. The EPSDT is -- it affects children under the age of

21.

SENATOR ANTONACCI: And we're not doing that right now?

MS. URSITTI: We are not doing that right now, no.

SENATOR ANTONACCI: And that would bring us in compliance with the federal Medicaid law?

MS. URSITTI: Yes.

SENATOR ANTONACCI: And Oklahoma just had an adverse decision against them to cover that same population?

MS. URSITTI: They did. There was an opinion last week in the courts; they agreed with the plaintiff that this is medically necessary care, applied behavior analysis is, and they're having to come into compliance.

SENATOR ANTONACCI: Okay, I got it. I just want to ask you a question, and you can tell me it's urban legend and it's a myth, but I want to give you a chance to dispel it in my mind. I had a friend that had a very healthy young child, boy, a bouncing baby boy, goes to the doctor, gets about 12

immunizations. He was sick that day, and then he's on the spectrum. And to this day my friend will not believe anything other than immunizations cause that.

We've got some mandatory immunization law coming down the pike, I believe. Myth -- is there any truth to it? And are we minimizing the amount of immunizations that are given to a child in any one given day? Just why not, I guess would be -- why not do it that way? But please -- you've got a minute if you'd like.

MS. URSITTI: I will say I'm not from the science department of Autism Speaks, but I can say as an advocate for Autism Speaks that we don't know what causes autism, we don't know the biology of autism. There are many theories out there, and we need to be looking at all of them.

SENATOR ANTONACCI: So there is no definitive reason for autism?

MS. URSITTI: No. It's diagnosed through the DSM, through criteria that's met under the DSM. And so you can't do a blood

test or an MRI and say this person has autism. And so research really needs to be conducted that looks at all aspects -- genetic, environmental, everything, to determine what the cause of autism spectrum disorder is.

I have a child with autism, and I definitely would love to know why he's so severely affected.

SENATOR ANTONACCI: And does it affect boys more than girls?

MS. URSITTI: Four times more than -- boys than girls.

SENATOR ANTONACCI: All right, thank you.

CHAIRWOMAN KRUEGER: Assembly?

CHAIRWOMAN WEINSTEIN: Assemblyman Abinanti.

ASSEMBLYMAN ABINANTI: Thank you for your presentation.

You've been doing this a while, haven't you?

MS. URSITTI: You too.

ASSEMBLYMAN ABINANTI: Yes. Didn't we

work together to get a change in the state law about 10 years ago?

MS. URSITTI: We sure did.

ASSEMBLYMAN ABINANTI: That requires private insurance companies to cover ABA.

MS. URSITTI: Right. Right.

ASSEMBLYMAN ABINANTI: And we did not include Medicaid.

MS. URSITTI: We included Child Health Plus, but at the time Medicaid was not included, regretfully.

ASSEMBLYMAN ABINANTI: Okay. Thank you for pointing that out.

CHAIRWOMAN WEINSTEIN: Thank you. Thank you for being here.

SENATOR KRUEGER: Senator Gustavo Rivera. We're not quite done.

SENATOR RIVERA: Thank you for your testimony.

I just want to make sure that we get a couple of things on the record. By the way, my older brother is autistic as well. He's on the spectrum diagnosed very early, in like '71. So the spectrum disorders were still

being kind of determined, right? So if you met him, you'd just think he was eccentric.

Anyway, wanted to make sure that we got some stuff on the record. As you said, there is still a lot of the research that needs to be done, as far as autism is concerned, to determine exactly what it comes from. However, can you definitively say that there is no evidence, there's no hard evidence that -- that --

CHAIRWOMAN KRUEGER: Vaccines?

SENATOR RIVERA: Thank you, vaccines. Again, this is what happens. It's what, 6:50. I've been here since 9:30. Words continue to escape me. Vaccines.

There is no hard evidence that vaccines cause autism, is that correct or incorrect?

MS. URSITTI: The research to date does not indicate a link.

SENATOR RIVERA: Okay. Considering there's this one study that floated around a couple of years ago, which was then debunked shortly thereafter, and everyone kind of

quotes that one, as opposed to everything else, that says that vaccination as a process of creating herd immunity to keep diseases that we've been able to keep out of populations, that that does work. Right? Vaccination does work.

MS. URSITTI: Autism Speaks recommends that people work with their physician and vaccinate their children.

SENATOR RIVERA: Okay. Thank you, Madam Chair.

SENATOR KRUEGER: Thank you. I also have a question. I also thank you both for coming to testify.

So I've been following research in cannabis products outside the U.S. because they allow research and we don't seem to. And there seems to be some very promising research out of Israel that cannabis oil can actually have a significant impact, particularly on young children in a variety of the issues that actually you were describing when describing the patients you work with.

I know it's -- you're not a medical research institution, but are --

MS. URSITTI: We actually are a research organization.

CHAIRWOMAN KRUEGER: Okay. It does say that on your paperwork, thank you.

MS. URSITTI: Yes. I'm a CPA, though, not a scientist.

SENATOR KRUEGER: We all pretend to be elected officials, but we'll leave that alone.

(Laughter.)

CHAIRWOMAN KRUEGER: Do we think that -- based on what you and the community you work with talk about, do you think there's some real promise for us here with cannabis oil?

MS. URSITTI: Yes. In fact our science department at Autism Speaks brought together researchers from all across the world in November, and they're generating a white paper to give good information to people about cannabis. Because you're right, we're hearing so many studies from other

places, and our community is definitely desperate for interventions that are accessible and that can make a difference.

I do want to say that behavioral interventions, like applied behavior analysis, are evidence-based and life-changing, so they can truly make a difference.

Also addressing issues with GI system can really make a difference when it comes to behavior. So there are different aspects to treatment. But definitely the cannabis is something that our science department is actively looking at, and we will be generating a white paper. Although white papers -- who needs another white paper. But we do need one for this. And so that research is being worked on.

SENATOR KRUEGER: And I didn't mean to imply that there's any magic bullet, because I don't think any of us think there is.

MS. URSITTI: Oh, I know we wish there was.

CHAIRWOMAN KRUEGER: Me too.

MS. URSITTI: And I do want to say that autism can be a gift for many people. But there are challenges related to it that affect the person, affect the family. And so it's critical that people have access to meaningful services.

SENATOR KRUEGER: I think many of us probably have family members with autism and all have personal experience. But when I read about the cannabis opportunities and I think about some of the much more high-risk drugs that some people are being advised to prescribe to their children to keep them under control -- antipsychotics with all kinds of long-term risks involved -- I personally am very excited that as this country and as this state moves forward with medical research using this product called cannabis, that we might actually find there are many opportunities for us.

MS. URSITTI: Just a quick addendum to that. I'll say Autism Speaks has lots of toolkits through our family services department. We have toolkits for Early

Intervention and we have toolkits for school or community-based services. One of the most downloaded toolkits of Autism Speaks is our challenging behaviors toolkit, because families are really suffering. The day we introduced it, our servers crashed because so many people need access to services that are going to help with those challenging behaviors. So cannabis definitely could be something that can make a difference.

SENATOR KRUEGER: Now I'm breaking our rules, I'm sorry. Thank you both very much for being with us tonight.

MS. O'GRADY: Thank you.

MS. URSITTI: Thank you.

CHAIRWOMAN KRUEGER: New York State Association of County Health Officials, Paul Pettit.

(Discussion off the record.)

CHAIRWOMAN KRUEGER: I'm sorry, Alzheimer's Association had to leave, so that's why I skipped them.

New York Association of County Health Officials, followed by Communication Workers

of America.

SENATOR RIVERA: Home stretch. Home stretch.

SENATOR KRUEGER: Followed by Housing Works.

Is the County Association of -- oh, you are, good. We had your paperwork, so we were hoping we would see the humans. Great.

MR. PETTIT: We're hanging in there till the end. We're your public health officials, so --

CHAIRWOMAN KRUEGER: You're proving it.

MR. PETTIT: That's right. We're working around the clock to protect the health of the public.

(Laughter.)

SENATOR KRUEGER: Good evening.

MR. PETTIT: Good evening. Well, good evening, Senator Rivera, Assemblyman Gottfried, Senator Krueger and Assemblywoman Weinstein and distinguished committee members. Thank you for the opportunity to provide testimony on the 2019-2020 Executive

Budget proposal. My name is Paul Pettit. I'm the public health director for Genesee and Orleans County Health Departments. And I'm here today on behalf of the local health departments of New York State in my role as president of NYSACHO, the New York Association of County Health Officials.

I'm also joined by Sarah Ravenhall, our executive director.

NYSACHO represents all 58 local health departments, including the City of New York. We are the chief health strategists in our community, and it is our job to protect the health of the 20 million New Yorkers collectively represented by you and your colleagues.

The Governor's Executive proposal includes exemplary public health policy changes we strongly support; among them, protecting children from lead exposure and increasing the legal age for tobacco and vaping to 21 statewide. As you know, local health departments will play essential roles in the success of these policies.

We are very pleased to see and fully support the adoption of the Governor's Tobacco 21 plan and all the components of the tobacco control package. We recommend its passage completely, particularly if legalization of marijuana moves forward.

The Executive proposal also introduces public health policy that will bring a substantial increase in workload to local health departments. While we remain committed to carrying out strong public health policy, we must also insist flexible funding be allocated to any changes in policy that will substantially increase workload.

We'd like to thank Senator Rivera and Assemblyman Gottfried for raising the concerns around cuts to Article 6 earlier today with the commissioner. We share your concerns. We urge you to reject the proposed cut in state aid reimbursement to the New York City Department of Health and Mental Hygiene and, furthermore, to go beyond restoration by increasing the funding for all local health departments to a level that will

enable us to add capacity, respond to emerging issues, and defend the health and safety of our communities.

We strongly recommend approaching the discussion of legalizing adult-use marijuana slowly and cautiously, taking into account the voices of local professionals, with the interests of public health at the forefront of decision-making. NYSACHO maintains a strong opposition to legalized adult-use marijuana based on the quantifiable adverse impact it will have on public health.

However, we must be prepared to mitigate and respond to those threats if it becomes the will of our government to enact them.

Maintaining core services and the success of new and expanded public health policies can only be achieved with the investments in either Article 6 state aid or within flexible grant programs. For example, NYSACHO conceptually supports primary lead poisoning prevention activities which are included in the Governor's Lead Safe housing

policy. However, to adopt the policy without the funding that's flexible enough for us to respond in our local health departments will eventually lead the policy to certain doom and failure.

Bottom line, public health policy and responses require public health resources.

Respecting the committee's schedule, I ask that you and your staff please refer to our formal submitted testimony which contains the specific information and funding levels we believe are minimally necessary to enable you to craft and properly resource effective public health policy.

As I speak, our members are executing response strategies to mitigate communicable disease outbreaks. Most notably is the current measles outbreak in Rockland County and the growing cases around the state. Staff in Rockland County have been at the front line working around the clock with schools and communities to ensure vulnerable populations are vaccinated and protected.

Local health departments continue to

serve on the front line in combating the opioid epidemic, by spearheading stakeholder collaboration, community education, first responder trainings and linkages to care for those at risk.

Of immense concern is the upward trend we are noticing in neonatal absentee syndrome, a condition caused by a baby being exposed to drugs in the womb before birth. Our departments work with these families to educate and ensure access to care and services are available.

Full-service health departments work to ensure safe communities and public water supplies through enforcement of sanitary codes and prevent environmental hazards through assessment, regulation and remediation.

These examples barely scratch the surface of the extensive lifesaving work that our local health departments do -- and our case in point why allocating flexible funding to public health prevention and programming is critical.

Together we should be candid about what investments are necessary to truly safeguard the health of the 20 million New Yorkers who trust us to protect them. To that endeavor, New York State's local public health officials will be your full and enthusiastic partners.

Thank you again for the opportunity to speak with you today -- tonight.

SENATOR KRUEGER: Hello.

MR. PETTIT: Hello.

CHAIRWOMAN KRUEGER: Senator Antonacci.

SENATOR ANTONACCI: Thank you. Thank you, Madam Chair.

I had an interesting argu -- discussion in the elevator, and I don't normally -- I broke my own rule in the elevator, but it was about marijuana. And this individual actually told me that smoking cigarettes were completely different than smoking marijuana. And you seem to say here that marijuana smoke may deposit more particulate matter.

Is marijuana smoke just as dangerous as regular smoke? And I realize there might be different amounts. But is it just as dangerous?

MR. PETTIT: I think one of the biggest things that we're, you know, proponents of is more research. I think there's still a lot of unknowns when it comes to that.

Our position is purely that anything that you inhale and bring into your lungs that's not pure air is something that we're not going to be supportive of in public health.

SENATOR ANTONACCI: Okay. And then can you -- is there a reason to smoke marijuana other than getting high? I actually -- this individual actually told me that you could actually smoke marijuana for other reasons other than getting high. And it was an argument over whether, you know, a glass of wine with your macaroni is an enjoyable glass of wine without getting wasted. Is there any --

MR. PETTIT: Again, I would state that we would not support any way of, you know, smoking and inhaling any type of smoke or anything. Obviously there is other venues with CBD oil and other ways --

SENATOR ANTONACCI: That's more medical, though, right? That's more medical.

MR. PETTIT: Yeah, more medical on that side, correct.

SENATOR ANTONACCI: And then lead poisoning -- by the way, I worked with a great health commissioner, Dr. Cynthia Morrow.

MR. PETTIT: Yes.

SENATOR ANTONACCI: I don't know if you ever heard of Cynthia --

MR. PETTIT: Yup.

SENATOR ANTONACCI: -- but she was fantastic.

But lead -- I can't believe -- my city, Syracuse, is one of the most impoverished cities in the nation. And I thought we did everything we already needed to do for lead paint, and now we've got

another epidemic. Any quick suggestions?

MR. PETTIT: Yeah. So, you know, any amount of lead is dangerous and we want to see no levels of lead in our children. But we have seen an uptick and we continue to see elevated lead cases around the state.

You know, the proposal that the Governor has put forth to lower it down to 5 is something, again, that we in our local health departments continue to do education and nursing intervention at 5.

The concern here is the lowering of the environmental action level down to 5 from 15. There's been $9.4 million allocated in Article 6 funding, but we have noted -- and you'll see that in our materials -- is that is not a sufficient way to fund our program.

SENATOR ANTONACCI: So you're looking for more money in that program.

MR. PETTIT: Well, we're currently working on pulling together the data. We just found out about these more restrictions and regulations they are proposing.

But we do know that, you know -- the

caseload for environmental I can give you for my counties, we currently have about 16 where we did environmental assessments in 2018. Under the new regulations at 5, it would jump up to about 145, a tenfold increase.

SENATOR ANTONACCI: So it sounds like you need more money.

MR. PETTIT: And not only more money, but flexible funding is very important for us.

SENATOR ANTONACCI: Okay. Real quick, I think we can get this in. Getting back to vaccinations, I just want to make sure. I'm not advocating no vaccinations. I was of the opinion that it was the combining of multiple applications of vaccine on the same day.

Real quick, I know that there's a law potentially coming, I know we've got a measles outbreak. How do you weigh that against freedom of religion? And does the overriding of the health concern and the measles outbreak override any of those issues?

MR. PETTIT: Obviously we're very

pro-vaccination and we really, you know, strongly educate and push folks to go that direction. You know, obviously herd immunity is very important, and that's what we're really seeing in these outbreaks, in these clusters that are occurring, you know, the failure, obviously, to get vaccinated due to various religious exemptions, et cetera.

And, you know, this is the end result of what we're seeing, so we're continuing to educate.

SENATOR ANTONACCI: All right, thank you.

SENATOR KRUEGER: Thank you.

Assembly.

CHAIRWOMAN WEINSTEIN: Assemblymember Abinanti.

ASSEMBLYMAN ABINANTI: Yes, thank you. I don't know how we got into talking about vaccines. I think that should be a separate discussion, because we have various views. And I will just put on the record that I'm disappointed we've gotten into this budget discussion when it deserves a real serious

discussion that we've never had. And there are lots of viewpoints that have been simplified by some members of the panel, and I think they're actually misrepresenting what the -- that it does in fact show. But I'm not going to get into that now, I'm just going to say that.

I'd like to talk to you about two things. One, Early Intervention. You said the Executive Budget proposes a 5 percent rate increase, but most of this is going to be borne by the local governments. Why?

MR. PETTIT: Well, so this is -- obviously we've heard a lot of conversation today around Early Intervention and the rate increases. And as most of you know, local health departments are the stewards and ones that oversee the programs in most counties; again, it does fall on some other departments.

But, you know, we've continued to see a lack of providers --

ASSEMBLYMAN ABINANTI: Right. But why is going to cost you more money?

MR. PETTIT: What's that?

ASSEMBLYMAN ABINANTI: Why is it going to cost you more?

MR. PETTIT: Well, essentially what's happening -- and I can speak again from -- personally within our county, what's happening is once the state fiscal agent went in place, the providers, you know, are dropping out and the capacity is an issue that we're facing all the way around, and they're not collecting third-party reimbursement, and so essentially that's falling back to the counties and to the state to pick up the cost.

ASSEMBLYMAN ABINANTI: Okay, the second thing was -- well, as part of that, would having ABA covered by Medicaid help a little bit there?

MR. PETTIT: Yes. Yup.

ASSEMBLYMAN ABINANTI: So you would support that proposal that was made.

MR. PETTIT: Yes.

ASSEMBLYMAN ABINANTI: The other thing was you suggested here that you didn't like

the idea of the Governor removing the Justice Center from jurisdiction over regulation of children's camps. Before the Justice Center, didn't you have the control of those camps anyway?

MR. PETTIT: I can't speak directly to going back that far, but it's one of those where we obviously are very involved in the permitting process, doing background checks, making sure that the camps are safe, you know, for our children to go and partake in the different activities.

The Justice Center has a unique set of focuses there that we don't have the resources and the capacity to do at this point.

ASSEMBLYMAN ABINANTI: Are you familiar with all of the issues that have been raised about the Justice Center and its --

MR. PETTIT: Yes.

ASSEMBLYMAN ABINANTI: -- and the way it operates?

MR. PETTIT: Yes. You know, it's one

of those -- again, when we talk about new programs and new services, it goes back to, you know, kind of the mantra of the testimony here, is we need flexible funding and resources to take on additional work.

ASSEMBLYMAN ABINANTI: So you just don't want the additional work coming back to you, you don't care who out there regulates them.

MR. PETTIT: Well, I think, again, that's something that could be discussed further. But I do know that we can't continue to take additional workloads without funding.

ASSEMBLYMAN ABINANTI: Right. I just want to make sure you're not endorsing the Justice Center's role in this.

MR. PETTIT: No. No. We're just pushing back on the fact, again, of our role and our expertise isn't necessarily in that area.

ASSEMBLYMAN ABINANTI: There seems to be a tendency in this budget and several others that have been proposed of shifting

the burden to local governments and not following it with money. That's your point.

MR. PETTIT: Yes.

ASSEMBLYMAN ABINANTI: Okay, thank you.

SENATOR KRUEGER: Thank you.

Senator Rivera.

SENATOR RIVERA: So thank you for sticking with us as long as you have.

MR. PETTIT: Sure.

SENATOR RIVERA: We're in the home stretch.

So regarding lead, I want to actually suggest something to you. As an organization, I would actually ask you to see if you would perhaps want to put forward a memo of support for a bill that I have related to lead. Although I'm supportive of the Governor's proposal, one of the issues that I have with it and one of the things that my bill seeks to do is to actually create a mechanism by which localities like yourselves, right, can actually go to the state and request money for either testing or

remediation, so that you are not stuck with like saying, hey, we obviously don't want lead in our kids' blood, but we would probably want to have some money that is attached to that.

MR. PETTIT: Yes.

SENATOR RIVERA: It is called Dakota's Law. I can certainly give you the bill number later. It refers to -- Dakota is the name of a daughter of one of my constituents, a NYCHA, New York City Housing Authority resident whose kid unfortunately got poisoned. And one of the things that she did afterwards is that she sued NYCHA and won, but then she sat down with staff and worked through what are the things that were obstacles in her seeking to identify whether her child had an elevated blood level -- an elevated level of lead in her blood, and then to try to figure out how we can remove barriers.

And then considering that it is a statewide issue, as it refers to localities outside of the City of New York, I want to

make sure that you have -- not only that you have the standard lowered so that -- the threshold is lowered so the standard can be raised, but also that you have an ability to ask the state for money.

So I can share with you that number later, but maybe you would like to potentially support that.

MR. PETTIT: That would be great on both fronts, to share that and have that flexible funding that we need.

SENATOR RIVERA: Yeah. And I certainly would -- you know, it's a pitch to my Senate colleagues that maybe you want to jump on, just a quick plug there.

Thank you for hanging in with us.

Thank you, Madam Chair.

SENATOR KRUEGER: Thank you very much for your testimony tonight.

Our next testifier, plural, Communications Workers of America, AFL-CIO. I think we have Deborah Hayes, area director upstate, Cori Gambini and Sarah Buckley.

I have two of the three. You'll tell

us which two of the three you are.

MS. BUCKLEY: I'm Sarah Buckley.

MS. HAYES: Good evening. And thank you for giving us the opportunity to testify today about the staffing crisis in New York's hospitals and nursing homes.

My name is Debbie Hayes, and I'm the upstate New York area director for the Communication Workers of America, and I'm also a registered nurse.

CWA represents about 100,000 people in New York State, and 15,000 of those members are healthcare workers. We not only represent our end, but we also represent people that do dietary, housekeeping, and all the way up to nurse practitioners and physician's assistants.

So ensuring safe staffing levels and patient safety has been a priority for me over my 40-year nursing career. Whether it was my own experience at the bedside, the experiences of the members that we represented, or now listening to my own daughters describe to me the harrowing

descriptions of a night at work, working to provide high-quality care for patients has been a top priority of ours for a long time.

We hear daily from our members about the impossible choices that they have to make during a shift because they are short-staffed. And it's not a decision like should I grab something to eat or should I run to the bathroom, because lunches and breaks are missed constantly and on a daily basis. Our nurses must decide who gets cared for and who must wait, who will get a pain shot, who has to wait, whose treatments will be administered to them and whose care will be left undone for the shift.

So all of those decisions have life-and-death consequences. And the toll of this type of care delivery is devastating for the nurses that have to provide it. We actually have members -- and I know there was some talk about the nursing shortage today. We have members that leave nursing rather than be responsible for providing substandard care or working in the kind of environments

that they have to on a daily basis. Depression and burnout are highly visible in our profession.

We do document the horrendous conditions on what we call protest of assignment forms. And Sarah brought about 340 forms that she was just able to pull together over a couple of days. It represents filings from three health systems, and averages out to be at least three forms per day.

So I think earlier these were referred to as anecdotes, and I take exception to that because they're documented instances of where in an ICU you should have 16 nurses and you have 14 nurses, and the care that's being delivered to patients is inadequate.

The most difficult anecdote for me -- non-anecdote for me goes to a day when I was called as a union representative to sit with a nurse who had been a nurse for a very long time in a neuro-intensive care unit. And a one-decimal-point error that she made because she was running between three patients

instead of one or two resulted in the death of the patient.

And I remember her being distraught because she said to me, "I have been involved in the death of a father, of a husband, and a grandfather." And you don't recover from instances like that.

CWA has made numerous efforts over the years to negotiate safe staffing levels in our collective bargaining agreements, with limited success. So it is clear to me at this point that if we are going to end the crisis in patient safety in our hospitals and nursing homes, the budget must include clear language -- can I just finish that sentence?

SENATOR KRUEGER: That sentence, yes.

MS. HAYES: -- clear language empowering the Department of Health to regulate staffing, with clear instructions given to the Department of Health that a new staffing regulatory plan must be devised and implemented.

SENATOR KRUEGER: Senators, any questions? Assemblymembers?

CHAIRWOMAN WEINSTEIN: Nope.

CHAIRWOMAN KRUEGER: Wait.

Oh, Senator Gallivan, welcome.

SENATOR GALLIVAN: I have no questions, but I'd be remiss if I didn't welcome you from Western New York. You hung in here this late, and you have the longest ride home --

MS. HAYES: We have the longest ride home.

SENATOR GALLIVAN: And your people do great work.

MS. HAYES: Thank you.

SENATOR GALLIVAN: I don't recall, do you represent the nurses at Mercy?

MS. HAYES: We do.

SENATOR GALLIVAN: My wife was in there two times in the past month, and they did an outstanding job.

MS. HAYES: Thank you. I will get that back to them --

SENATOR GALLIVAN: Please do.

MS. HAYES: -- because they appreciate that, yes.

Okay, thank you.

SENATOR KRUEGER: We've all had experiences that make us remember that the quality of care you get in a hospital is based on the nurses.

So thank you both for being here tonight representing so many people who work so hard.

MS. HAYES: Thank you.

SENATOR KRUEGER: And our next and final testifiers, Housing Works, Charles King -- I don't see Charles. Oh, you're representing Housing Works. Hello. Elizabeth Deutsch?

MS. DEUTSCH: Correct.

CHAIRWOMAN KRUEGER: Thank you.

And you're on your own tonight?

MS. DEUTSCH: I am.

SENATOR KRUEGER: Because you were the one who held out. Thank you.

MS. DEUTSCH: I'm the only one who didn't have to be on a plane.

SENATOR KRUEGER: All right. Good evening.

MS. DEUTSCH: Good evening. Thank you for the opportunity to present testimony to the Joint Budget Hearing on Health and Medicaid. My name is Elizabeth Deutsch, and I am the New York State director of community mobilization for Housing Works, and I am also a registered nurse.

Housing Works is part of the End AIDS New York 2020 Community Coalition, a group of over 90 healthcare centers, hospitals and community-based organizations across the state. Housing Works is fully committed to realizing the goals of our historic New York State plan to end our HIV and AIDS epidemic by the year 2020.

I am testifying here before you today because I believe that 2019 will be a historic year of legislative achievements for the New York State Senate and Assembly, including the exciting opportunity for the Legislature to bring new energy and ambition to addressing the state's longstanding health crisis.

Especially now, New York State must

lead the nation on public health. Governor Cuomo's Executive Budget does not rise to this historic moment. And while the Governor has advanced some unique and groundbreaking initiatives such as ending the HIV/AIDS epidemic and hepatitis C elimination, healthcare proposals in the Executive Budget fall dangerously short on concrete commitments to achieve these goals.

We have asked the Governor to make the following urgent changes to the healthcare proposals in the 30-day amendments to the Executive Budget, and we call upon the Legislature to advance the initiatives outlined below whether or not the Governor takes action.

Housing Works also asks the Legislature to build on Governor Cuomo's $5 million initial investment in the Executive Budget towards eliminating the state's hepatitis C epidemic. We strongly urge the Senate and Assembly to include an additional $10 million, for a total $15 million investment in the state's

hepatitis C response in the Senate and Assembly one-house budget bills.

The proposed $26.85 million cut to New York City healthcare through reducing the rate of the Article 6 state match for healthcare funds by 16 percent is an unacceptable proposal that would severely damage health services in New York City and put lives at risk. We call on the Governor to immediately reverse these cuts in his 30-day amendments, and we call on the Legislature to take action if the Governor insists on advancing these catastrophic and inhumane cuts to New York City health programs.

We call on the Governor and Legislature to include funding in the enacted budget to offset federal cuts to New York STI and TB funding in order to maintain and strengthen the state's STI and TB responses. The federal cuts are hitting New York State during a spike in STIs.

We also urge the Governor and Legislature to reverse the proposed

$5 million reduction to the Medicaid Health Home Program, which will cut life-saving services and care coordination to the highest-need New Yorkers with chronic health conditions. The Health Home Program was already greatly reduced in last year's budget and simply cannot sustain further cuts.

The Executive Budget's proposal to establish a universal healthcare access commission with a report due a year from now recklessly kicks the can down the road while hundreds of thousands of New Yorkers go without insurance. Housing Works urges the Legislature to take immediate action in the one-house budget bills to establish a state-funded Essential Plan to expand coverage to all immigrants in New York State who earn less than 200 percent of the federal poverty level. This proposal could be partially financed with revenue from an individual mandate fee, and we have identified other potential sources of revenue to finance this proposal.

The Governor is fond of saying

New York stands with immigrants. If that is true, why are undocumented immigrants the only adults in the state who do not have access to basic primary and preventive care and health insurance?

Finally, the Executive Budget does far too little to address the overdose crisis, which has taken the lives of 20,059 New Yorkers since Governor Cuomo's first year in office. The Governor has failed to lead by not using his authority to authorize an overdose prevention center pilot, even though he made an explicit promise to community members to authorize a pilot last year.

In the face of the Governor's inaction, we encourage the Legislature to lead a unified, statewide public health-focused effort to combat the state's opioid epidemic, starting with piloting five overdose prevention centers across the state in partnership with existing syringe exchange program sites. Housing Works asks for the Legislature to be bold when it comes to addressing the state's public health crises.

Our progress against the state's AIDS epidemic shows us what can be achieved by implementing evidence-based policies. Together we can not only push the AIDS epidemic beyond the tipping point and secure our state's place as the first jurisdiction in the nation and the world to end its HIV/AIDS epidemic, but we can also eliminate hepatitis C, overdose deaths, and expand health coverage to all New Yorkers. These are not dreams. They are future realities if you act now.

SENATOR KRUEGER: Any Senators have any questions? Assembly?

SENATOR RIVERA: One.

CHAIRWOMAN KRUEGER: One. Senator Gustavo Rivera for the last question.

SENATOR RIVERA: (Imitating accent.) So why is Charles not here? I just wanted that to be on the record, Charles ain't here. I'm not happy.

(Laughter.)

SENATOR RIVERA: You're good, and I agree with everything you said.

MS. DEUTSCH: I will take that back to Charles.

SENATOR RIVERA: Charles not being here? I'm not happy.

Thank you, Madam Chairwoman.

(Laughter.)

SENATOR KRUEGER: We may not have any brains left, but we have a little bit of a sense of humor.

So thank you very much for sticking it out and being the last testifier tonight. And more serious minds will be reviewing the testimony than what you think you're getting tonight. Thank you.

This is the end of the Health hearing. At 9:30 tomorrow morning, same room, Elementary and Secondary Education. Thank you.

(Whereupon, the budget hearing concluded at 7:23 p.m.)