1 BEFORE THE NEW YORK STATE SENATE FINANCE
AND ASSEMBLY WAYS AND MEANS COMMITTEES
2 --

3 JOINT LEGISLATIVE HEARING

4 In the Matter of the
2020-2021 EXECUTIVE BUDGET
5 ON HEALTH AND MEDICAID

6 --

7
Hearing Room B
8 Legislative Office Building
Albany, New York
9
January 29, 2020
10 9:34 a.m.

11

12 PRESIDING:

13 Senator Liz Krueger
Chair, Senate Finance Committee
14
Assemblywoman Helene E. Weinstein
15 Chair, Assembly Ways & Means Committee

16 PRESENT:

17 Senator James L. Seward
Senate Finance Committee (RM)
18
Assemblyman Edward P. Ra
19 Assembly Ways & Means Committee (RM)

20 Senator Gustavo Rivera
Chair, Senate Committee on Health
21
Assemblyman Richard N. Gottfried
22 Chair, Assembly Health Committee

23 Senator Neil Breslin
Chair, Senate Insurance Committee
24

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3 PRESENT: (Continued)

4 Assemblyman Kevin A. Cahill
Chair, Assembly Committee on Insurance
5
Senator Patrick M. Gallivan
6
Assemblyman Kevin M. Byrne
7
Assemblywoman Rodneyse Bichotte
8
Senator Brad Hoylman
9
Senator Diane J. Savino
10
Assemblyman Edward C. Braunstein
11
Senator Todd Kaminsky
12
Assemblyman Nader J. Sayegh
13
Senator Rachel May
14
Assemblyman Phil Steck
15
Senator Zellnor Myrie
16
Assemblywoman Marjorie Byrnes
17
Senator Elizabeth O'C. Little
18
Assemblyman Andrew Garbarino
19
Senator Anna M. Kaplan
20
Assemblyman Jonathan G. Jacobson
21
Assemblyman John McDonald
22
Senator Alessandra Biaggi
23
Assemblywoman Linda B. Rosenthal
24

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3 PRESENT: (Continued)

4 Assemblyman Jake Ashby

5 Senator Patricia A. Ritchie

6 Assemblywoman Michaelle Solages

7 Assemblywoman Patricia Fahy

8 Senator John C. Liu

9 Assemblywoman Judy Griffin

10 Assemblyman Félix Ortiz

11 Senator Jen Metzger

12 Assemblyman John Salka

13 Assemblywoman Marianne Buttenschon

14 Senator Susan Serino

15 Assemblyman Thomas J. Abinanti

16 Assemblywoman Aileen M. Gunther

17 Senator Robert Jackson

18 Assemblywoman Melissa Miller

19 Assemblyman Charles Barron

20 Assemblyman Michael Blake

21 Assemblyman Philip A. Palmesano

22

23

24

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1 CHAIRWOMAN KRUEGER: Good morning,
2 everyone. If people could get a chair and
3 get comfortable, this is the hearing on
4 Health.
5 We suggested last night, if people
6 were listening, that people might want to
7 bring sleeping bags or pajamas to today's
8 hearing; we expect it to go very late this
9 evening. Because of that, we have
10 established some rules for hearings that we
11 are trying to be fairly strict about, mostly
12 relevant to those of us in the Legislature.
13 But the first one, please pay close
14 attention to the clock. All right? The
15 government testifiers get 10 minutes to
16 testify. Then after we get past the
17 government testifiers, people have five
18 minutes to testify. We will cut you off.
19 We encourage you, especially people
20 who aren't going to be testifying until much
21 later today, do not read your testimony.
22 People have some fantasy that they have
23 20 pages and they can get through it in five
24 minutes. It's just never been true.

1 So we all get copies of everyone's
2 testimony. It goes up on the hearing site
3 for the public to have access to as well.
4 What we hope you will do is bullet point the
5 key issues within your testimony, and don't
6 find yourself in a situation where you made
7 the most relevant parts of your very long
8 testimony the last few pages, which you will
9 never get to. So start in the back if that's
10 what you did in your written testimony.
11 Again, we are legislators; we have all
12 successfully learned to read.
13 Okay. The chairpersons of the
14 relevant committees have a 10-minute
15 allotment for questions and answers of
16 government witnesses; all other legislators
17 have five minutes of government reps. Except
18 for the relevant chairs -- for example,
19 Health for our first group of panelists, the
20 Health chairs will get a second opportunity
21 of five minutes each, that's it.
22 Any legislator who feels the need to
23 ask additional follow-up questions, you can
24 present them to Helene or myself and if we

1 can fit them in in the time we have, we try
2 to bat cleanup and cover issues that people
3 didn't feel they had a chance to ask.
4 When we shift to nongovernmental
5 witnesses many hours from now, legislators
6 will have -- sorry. When we get to
7 nongovernmental witnesses, again, you have
8 five minutes, but the legislators have three
9 minutes to ask you questions.
10 And then finally there are some
11 legislators who know that they really have
12 important questions and they still want to
13 get follow-up from the panelists, or the
14 panelist said "I'll get back to you with
15 that." We ask: Feed those questions into us
16 legislators and a letter will go out from
17 Helene and myself to do the follow-up to
18 that. We get it back to the committee and
19 will make it public to everyone.
20 And if you have questions as
21 individual legislators, if you would also get
22 them to Helene and I, we will make sure they
23 go out and that all members -- because if you
24 have a really critical question you were

1 hoping to get the answer to, I'm going to bet
2 most of your colleagues want to know the
3 answers as well.
4 Okay. So before I kick -- oh, no, now
5 I'm going to kick off the hearing. So hi,
6 I'm Liz Krueger, the New York State Senate
7 Finance Committee co-chair of today's budget
8 hearing. Helene and I -- Helene Weinstein,
9 Ways and Means chair, trade off every day
10 who's running the hearing, and this one is
11 the Senate's.
12 Today is the third of 13 hearings
13 conducted by the joint fiscal committees of
14 the Legislature regarding the Governor's
15 proposed budget for state fiscal year 2021.
16 These hearings are conducted pursuant to the
17 New York State Constitution and Legislative
18 Law.
19 Today the Senate Finance Committee and
20 the Assembly Ways and Means Committee -- we
21 should both have the same name for our
22 committees, it would be easier. Sorry --
23 will hear testimony concerning the Governor's
24 proposed budget for the Department of Health,

1 the Office of Medicaid Inspector General, and
2 the Department of Financial Services.
3 Following each testimony -- again, as was
4 just explained -- there will be time for
5 questions of the panelists by the
6 Legislature.
7 I will now introduce members from the
8 Senate and Assemblymember Helene Weinstein,
9 chair of the Assembly Ways and Means
10 Committee, will introduce members of the
11 Assembly. In addition, Senator Jim Seward,
12 ranking member of the Senate Finance
13 Committee, will introduce members of his
14 conference. I also want to recognize
15 Assemblymember Ra -- we didn't put you in our
16 speech, I apologize -- the ranking member for
17 the Assembly Republicans and a brand-new
18 member of this panel.
19 Okay, so representing each agency,
20 just briefly, I'd like to welcome Dr. Howard
21 Zucker, Donna Frescatore, Medicaid Director,
22 Department of Health. Dr. Zucker is
23 Commissioner of Health. And later we will
24 hear from Dennis Rosen, Medicaid Inspector

1 General, and Linda Lacewell, Superintendent
2 of the Department of Financial Services, and
3 they will each -- their testimony will be
4 followed up with questions from the
5 Legislature.
6 Okay, so introductions. I have with
7 me today Senator Breslin, who is the chair of
8 Insurance; Senator Todd Kaminsky, Senator
9 John Liu; Senator Gustavo Rivera, chair of
10 Health; Senator Brad Hoylman, Senator Diane
11 Savino; Senator Rachel May; Senator Jen
12 Metzger; Senator Myrie.
13 And would you like to introduce yours?
14 SENATOR SEWARD: Yes. Thank you. I'm
15 pleased to introduce the members of my
16 conference who have joined us here this
17 morning. First of all, our ranking member of
18 the Health Committee, Senator Gallivan. And
19 also with us today is Senator Betty Little
20 and Senator Sue Serino.
21 CHAIRWOMAN KRUEGER: Great. Assembly.
22 CHAIRWOMAN WEINSTEIN: We have with us
23 the chair of our Health Committee,
24 Assemblyman Gottfried; chair of our Insurance

1 Committee, Assemblyman Cahill; Assemblywoman
2 Bichotte, and Assemblyman Sayegh.
3 Mr. Ra, to introduce the Republican
4 members of the panel.
5 ASSEMBLYMAN RA: Thank you. We have
6 with us the ranking member on the Health
7 Committee, Assemblyman Kevin Byrne; our
8 ranking member on the Insurance Committee,
9 Assemblyman Andrew Garbarino; our ranking
10 member on the Aging Committee, Assemblyman
11 Jake Ashby; as well as members of the Health
12 Committee, Assemblywoman Missy Miller and
13 Assemblyman John Salka.
14 CHAIRWOMAN WEINSTEIN: And we were
15 joined by Assemblyman Braunstein also.
16 CHAIRWOMAN KRUEGER: So, Dr. Zucker,
17 if you would please start your 10 minutes of
18 testimony.
19 COMMISSIONER ZUCKER: Thank you very
20 much. Good morning, Chairpersons Krueger and
21 Rivera, Weinstein and Gottfried, and members
22 of the New York State Senate and Assembly.
23 I am here to present Governor Cuomo's
24 fiscal year 2021 Executive Budget as it

1 relates to the health of all New Yorkers. I
2 am joined by Donna Frescatore, the State
3 Medicaid Director and Director of the
4 New York State of Health.
5 As you are aware, New York State faces
6 a significant budgetary challenge this year.
7 But from the perspective of the Department of
8 Health, challenges are everyday events and
9 not things that bring systems to a halt.
10 Just last year the state experienced the
11 largest measles outbreak in 30 years,
12 primarily in New York City and the Lower
13 Hudson Valley area.
14 The outbreak and the department's
15 response were unprecedented in our measles
16 elimination era. The department collaborated
17 with our local health and community partners
18 to combat the outbreak through education,
19 contact investigations, and ultimately the
20 administration of nearly 85,000 doses of the
21 MMR vaccine -- mumps, measles and rubella
22 vaccine -- in the affected counties.
23 The Governor signed legislation
24 removing vaccination exemptions that could

1 have made the outbreak worse, and we thank
2 our partners in the Legislature for that
3 effort. In the end, we successfully
4 contained an aggressive outbreak and stopped
5 the United States from losing its measles
6 elimination status.
7 But before we even had the chance to
8 exhale, we found ourselves face-to-face with
9 a new health threat, a severe pulmonary
10 illness associated with the use of vaping
11 products. The challenges here were twofold:
12 legal e-cigarette flavorings that hook kids
13 on nicotine through predatory marketing, and
14 the dangerous vaping products sold in the
15 illegal, unregulated market.
16 The department led with a vigorous
17 response consisting of regulations to ban the
18 sale of flavored e-cigarettes, public
19 education, case investigations, laboratory
20 testing, and a series of proposed
21 legislation.
22 Our own Wadsworth Center was the
23 nation's first laboratory to identify vitamin
24 E acetate in the illicit vaping products as a

1 likely source of this illness. Our discovery
2 framed a national narrative and led to
3 accolades from the Centers for Disease
4 Control.
5 And now, just a few months later, we
6 are doing the same with the evolving threat
7 of the novel coronavirus. Internally, the
8 department had it pegged as a likely new
9 coronavirus when it was still being labeled
10 internationally as a mysterious pneumonia
11 virus. It was nowhere on the health radar
12 even two months ago, and now we're once again
13 at the forefront of the issue.
14 The ongoing and new challenges met and
15 addressed by the Department of Health are
16 manifold -- Zika, Ebola, and C. auris, which
17 is the medication—resistant infection that's
18 increasingly being identified in long-term
19 healthcare settings. Two years ago, on the
20 100th anniversary of the 1918 influenza
21 pandemic, we experienced one of the worst flu
22 seasons since we began tracking in 2004. And
23 this year we again are facing an
24 uncompromising influenza season, while

1 tackling a hepatitis A outbreak in several
2 parts of the state. And when it gets warmer,
3 we will collect and test over 100,000 ticks
4 to combat the ongoing challenge of Lyme
5 disease.
6 We are not just reactive to public
7 health challenges, we are proactive -- taking
8 action and making investments to protect
9 drinking water from contaminants,
10 investigating counties with atypical cancer
11 rates, and implementing strategies to prevent
12 maternal mortality. The department always
13 puts public health first, period.
14 We in New York know that access to
15 healthcare is critical. Today 95 percent of
16 the state's residents have health insurance.
17 That's over 18 million New Yorkers. Critical
18 to this achievement is the 2014 launch of
19 New York State of Health, which provides
20 crucial low-cost and no-cost health coverage
21 to 4.8 million people, one in four
22 New Yorkers. Enrollment in the New York
23 State of Health is still open, and in fact we
24 just extended it for an additional week. But

1 already this year's enrollment is at its
2 highest point ever.
3 Under Governor Cuomo's leadership,
4 this agency is always prepared for the next
5 challenge, the next public health threat, the
6 unexpected, because we know we are never done
7 with what we're doing.
8 Pivoting to Medicaid, it is true we
9 have a structural deficit this year, but we
10 have met these challenges before. In 2011,
11 Governor Cuomo created the first Medicaid
12 Redesign Team, which successfully developed a
13 series of recommendations to immediately
14 lower costs, increase efficiencies and
15 effectiveness, and generally improve the
16 program. We have demonstrated that our
17 Medicaid program can achieve both
18 comprehensive coverage for those who need it
19 and financial sustainability. Although the
20 healthcare landscape throughout the country
21 has changed, New York's commitment to
22 delivering high-quality healthcare to more
23 than 6 million residents has not.
24 We must now recalibrate to ensure that

1 the original reforms are working as intended
2 and to innovate new solutions in order to
3 rise up to meet the changing landscape and
4 the changing demographics. To that end,
5 Governor Cuomo has announced that he is
6 reconstituting the Medicaid Redesign Team.
7 Through its stakeholder-led approach, MRT II
8 will advance new recommendations to reform
9 the state's Medicaid program, preserve
10 benefits, and identify $2.5 billion in
11 structural savings and efficiencies.
12 When circumstances are ideal, we can
13 use the benefits of greater efficiencies and
14 innovations to grow, experiment and do more.
15 But in times of hardship, we must come
16 together to ensure that these benefits are
17 preserved for those who need it most.
18 As I said at the start of this
19 testimony, this is a challenge, but it is one
20 we are uniquely prepared for. And we are
21 looking to you to be a partner in that
22 effort.
23 I am grateful for the opportunity to
24 share this information from the department.

1 We are happy to take your questions. But
2 please know that you will have further
3 opportunities after today, after this
4 hearing, to get the information you are
5 seeking. Our respective staffs are always
6 working together on these issues, and we'll
7 remain in close contact as we rise to this
8 challenge.
9 Thank you.
10 CHAIRWOMAN KRUEGER: Thank you. Our
11 first questioner will be Gustavo Rivera,
12 chair of the Senate Health Committee.
13 SENATOR RIVERA: Thank you, Madam
14 Chair.
15 Good morning to both. Let's get right
16 into it.
17 First of all, the original process --
18 please correct me if I'm wrong, but the
19 original MRT process that happened in 2011
20 started with an Executive Order that
21 impaneled, so to speak, the MRT and then was
22 given specific instructions so that by
23 March 1st of that year there would be
24 recommendations so the Legislature would have

1 a month to consider this before being
2 implemented in the budget. Is that correct?
3 COMMISSIONER ZUCKER: That's correct.
4 Correct.
5 SENATOR RIVERA: It is now
6 January 29th. Let's just make sure that we
7 check that date. Has there been an
8 Executive Order issued by the Governor to
9 empanel the MRT?
10 COMMISSIONER ZUCKER: Not yet. We are
11 working on it. We are working on it.
12 SENATOR RIVERA: Gotcha. Could you
13 tell me, outside of the Aid to Localities
14 budget, which is an 818-page document that
15 refers to the Department of Health,
16 outside -- is there any direct reference to
17 the MRT in the actual budget language? It's
18 a trick question, but I'll let you answer it
19 anyway.
20 MEDICAID DIRECTOR FRESCATORE: I
21 believe there's reference in the book. I
22 don't know if there is in the financial plan
23 specifically.
24 SENATOR RIVERA: Microphone a little

1 bit closer, please? I can't hear you.
2 MEDICAID DIRECTOR FRESCATORE: Yeah,
3 I'm sorry. Good morning, Senator.
4 SENATOR RIVERA: Good morning.
5 MEDICAID DIRECTOR FRESCATORE: I
6 believe there's reference to it in the budget
7 documents. I don't know that there is
8 reference in the financial plan.
9 I think we've been certainly at the
10 department for many months very clear that
11 the successful results we had from the
12 convening of the first MRT back in 2011,
13 which saved taxpayers, you know, tens of
14 millions of dollars --
15 SENATOR RIVERA: That's -- excuse me.
16 Since I have limited time, I will say for the
17 record the first MRT might not have been
18 perfect, but it achieved great things. So
19 let's not talk about that one anymore, let's
20 talk about the one that we're supposedly
21 putting together now.
22 MEDICAID DIRECTOR FRESCATORE: Fair
23 enough.
24 SENATOR RIVERA: Outside -- and I said

1 it's a trick question because outside of
2 references in like 15 different pages,
3 there's a particular language that does not
4 refer at all to an MRT. What it does -- in
5 other words, a Medicaid Redesign Team.
6 There's no actual mention of a Medicaid
7 Redesign Team. As opposed to that, there is
8 language -- I'm going to read some of it into
9 the record: "If on or before April 1, 2020,
10 the Legislature fails to achieve $2.5 billion
11 in aggregate savings from the appropriate
12 appropriations enacted as part of any
13 chapters of the Laws of 2020" -- making
14 appropriations for the Aid to Localities,
15 et cetera, et cetera, de-de-de-de, and then
16 it goes on to "uniform across-the-board
17 reductions shall be applied to such
18 appropriations to achieve $2.5 billion in
19 aggregate savings."
20 This is the question -- I wanted to
21 make sure we got to this point because we --
22 what detail do we actually have? For the
23 moment there is the mention of the MRT. What
24 is going to be the -- who are going to be the

1 members of the MRT? Could you tell us today,
2 please?
3 COMMISSIONER ZUCKER: At this point we
4 are working on that, and we will get that
5 back to you quickly.
6 SENATOR RIVERA: Okay. Again,
7 February -- I'm sorry, January 29th, right?
8 We're working on a timeline here. So --
9 COMMISSIONER ZUCKER: I will say that
10 we will -- we are going to look at all -- as
11 they did when they did the first MRT, look at
12 all the stakeholders who have an interest in
13 this will be represented, obviously the
14 Legislature as well --
15 SENATOR RIVERA: I was going to get to
16 that.
17 COMMISSIONER ZUCKER: -- and obviously
18 the legislators as well, and we will work
19 forward to address the changing landscape and
20 make sure there are any things that -- when
21 the first MRT was put together, things were a
22 little bit different.
23 SENATOR RIVERA: Got you. But as of
24 January 29th, we do not know who the members

1 are going to be. That's number one. We
2 don't know. Right? You all might know, but
3 we don't know.
4 Number two. The powers that this MRT
5 is going to have, there's no specificity of
6 it here. Right? Am I correct in that? Or
7 am I not -- am I missing something?
8 COMMISSIONER ZUCKER: We'll work all
9 this out. This is an ongoing process.
10 SENATOR RIVERA: All right. Third,
11 the timeline. It seems to me that the
12 timeline that's put here is completely
13 unrealistic, particularly since it is now,
14 again, January 29th and we don't have any
15 details.
16 So I just -- this is -- because
17 there's a couple of other things that I want
18 to cover, and I want to make sure that I get
19 some time. But this is the bottom line, and
20 I just want to make sure that this is a
21 publicly stated thing. We get it in the
22 Legislature, we get it, that there is a
23 crisis here and that we have to work together
24 to solve it. The best way to do that is to

1 actually be on the same page.
2 It is a little bit concerning --
3 scratch that -- a lot very concerning that
4 you are coming to a public hearing on
5 January 29th and you're telling us that by
6 April 1st we have to just accept something
7 that's going to be put together by a magical
8 crew of folks -- we don't know who they are,
9 we don't know the power that they have.
10 The timeline that they have is either
11 we accept it or, according to this language,
12 there's just an across-the-board cut. That
13 is not acceptable. And I'm saying it both to
14 you, as representatives of the Governor, and
15 I'm saying it to the Governor. It is not
16 acceptable that this is what you're asking us
17 to do. That's number one.
18 Let's get to the second part, which
19 is --
20 COMMISSIONER ZUCKER: Let me just
21 respond to you about the timing issue.
22 SENATOR RIVERA: Please.
23 COMMISSIONER ZUCKER: I mean, the
24 department has risen to the occasion, and the

1 entire administration, on many issues. And
2 even though you feel April 1st is right
3 around the corner, we will -- we will rise to
4 the occasion again and address all these
5 issues and move it forward as quickly as
6 possible and work quite diligently and quite
7 hard and long hours to get that done.
8 SENATOR RIVERA: Beautiful. Can I get
9 a commitment that we will -- like in 2011,
10 can we get a commitment that the Legislature
11 would have something to consider by March 1st
12 of this year?
13 COMMISSIONER ZUCKER: Well, I don't
14 want to commit to a day or a time, but -- but
15 we will -- we can get back to you on that,
16 exactly the time.
17 SENATOR RIVERA: So I will say
18 again --
19 COMMISSIONER ZUCKER: I understand.
20 SENATOR RIVERA: -- we -- it would be
21 preferable that we have some time as a
22 Legislature to look at whatever solutions.
23 And more importantly, as you referred
24 earlier, that we have a role in determining

1 what those policies are. We would love to be
2 participating.
3 And I know that many folks in this
4 room, the stakeholders -- since you talk
5 about stakeholders here, but there's no clear
6 line of who those stakeholders are. And
7 there's many stakeholders that need to be
8 part of that process.
9 Moving on. Let's talk about the Aid
10 to Localities thing. There is a way that you
11 are suggesting that localities across the
12 state would be penalized if they don't meet
13 certain criteria, so I just want to talk
14 about that for a second. Do we have -- there
15 is the issue of the 2 percent and the
16 3 percent. Right? That if a locality is
17 underneath the 2 percent property tax cap,
18 and then there's a 3 percent growth or less,
19 that they would be able to recoup some of
20 these savings that they recouped to the
21 state --
22 COMMISSIONER ZUCKER: If they stay
23 under that.
24 SENATOR RIVERA: Very well.

1 Can you point to me language in the
2 budget that actually lays out how a locality
3 would do that, number one?
4 COMMISSIONER ZUCKER: I'll go back and
5 look at that.
6 SENATOR RIVERA: Yeah. Trick question
7 again. Ain't there. All right? It's not
8 there. So you say that it is, but a press
9 release does not reality make. So I need to
10 know how the localities would do that. And
11 more importantly, what data are you relying
12 on that tells you -- there's 62 counties,
13 right, five of them in the City of New York.
14 So do you know -- could you provide us with
15 the data, because you haven't so far -- but
16 maybe you did today, I don't know. Can you
17 provide us with the data that tells us what
18 counties actually fall within the criteria
19 that you established?
20 COMMISSIONER ZUCKER: We can get you
21 that, exactly which counties.
22 SENATOR RIVERA: Again, thank you, I
23 guess. Ma'am.
24 MEDICAID DIRECTOR FRESCATORE: Well,

1 thank you. I mean, I'd like to -- you know,
2 I'd like to just, if I can at this point --
3 SENATOR RIVERA: Please.
4 MEDICAID DIRECTOR FRESCATORE: -- talk
5 a little bit about -- in response to your
6 question about what would you expect from
7 localities. And there is in the financial
8 plan a chart that shows, by locality, the
9 amount of Medicaid spending that has been --
10 that has been assumed by the state since the
11 takeover of the growth.
12 And I think you know those statistics,
13 Senator, that it's -- that for a number of
14 years the local contribution has been frozen,
15 if you will, at $7.6 billion, with
16 New York -- with the state assuming about
17 $4 billion a year in the additional growth of
18 the Medicaid program since that point in
19 time, cumulatively about --
20 SENATOR RIVERA: Since I have two
21 minutes -- I'm sorry to cut you off again.
22 I'm just going to be -- since they used --
23 since localities used federal and state
24 guidance on who is eligible, I'm not sure

1 that they have any discretion to determine
2 who's actually on their rolls or not. So how
3 is it that they're going to be held
4 responsible for things that they don't
5 necessarily have control over?
6 MEDICAID DIRECTOR FRESCATORE: Yeah,
7 so just maybe to level set here, locals make
8 about 47 percent of the eligibility
9 determinations. They're largely for people
10 who are in need of long-term care; people who
11 are eligible for Medicare and Medicaid,
12 dually eligible; and other individuals such
13 as people with excess income that spend down
14 to Medicaid.
15 And while for all of us Medicaid
16 eligibility is spelled out largely in federal
17 and state law, day to day we partner with the
18 locals in applying those rules and those
19 eligibility criteria.
20 And really what these proposals are
21 intended to do is to bring the districts and
22 my folks within the Office of Health
23 Insurance Programs to the table in
24 partnership to find savings and efficiencies.

1 The other important --
2 SENATOR RIVERA: Gotcha. I've got one
3 minute left, so I'm just going to -- I'm
4 going to cut you off. Just to -- one last
5 thing I want to -- just want to make sure
6 that we're on the record about.
7 So again, the MRT was a good thing
8 overall. It managed to flatten cost curves,
9 et cetera. The program kept existing. Can
10 we all get on the same -- can we all agree
11 that the formula that was created 10 years
12 ago is not -- is not operational anymore? If
13 I'm not mistaken, if we look at the numbers,
14 the cap has been pierced on basically every
15 year for the last, what, four or five years.
16 The question here is, do we need to
17 revisit whether the cap is a good idea? And
18 if it is, should we not revisit the formula
19 so that we're not -- because the reason --
20 because the reason that we're where we are is
21 that we set this artificial cap -- yes, it's
22 statutory, but we can move it, and then we'd
23 no longer find ourselves in a place where we
24 have to cut everything that you've cut

1 already, which, you know -- I'm going to come
2 back for five minutes later, so other folks
3 are going to go at you.
4 But just the last thing that I'll say,
5 it is not acceptable that you're not bringing
6 details to us that can help us make better
7 decisions about what this budget is going to
8 be. But I'm going to come back in a little
9 bit and --
10 MEDICAID DIRECTOR FRESCATORE: Okay,
11 and I'd like to address the question about
12 the cap, if I can, right here.
13 CHAIRWOMAN KRUEGER: The time is up
14 for this period. So I think you will have
15 more opportunities to answer about the cap,
16 because I suspect other people will also
17 focus on that.
18 And now it is the Assembly.
19 CHAIRWOMAN WEINSTEIN: We'll go to
20 Assemblyman Gottfried for 10 minutes.
21 ASSEMBLYMAN GOTTFRIED: Thank you.
22 (Off the record.)
23 CHAIRWOMAN KRUEGER: Something else I
24 forgot to mention, mostly to my colleagues in

1 the two panels here. Make sure your mike is
2 off when you're not the one talking, because
3 they're hot and people who are watching on
4 line are listening to every conversation.
5 And they don't really want to, they just have
6 no choice.
7 But so watch your mikes, that they're
8 on when they're supposed to be, and off,
9 because you never know who's listening.
10 (Laughter.)
11 ASSEMBLYMAN GOTTFRIED: Thank you.
12 And speaking of microphones, given the pretty
13 crummy acoustics in this room, it would
14 really be better if you could make an extra
15 effort to speak right into the microphone,
16 and louder, because otherwise it's really
17 hard to hear.
18 So a couple of questions. In 2011 the
19 MRT had its first meeting in mid-January. In
20 five or six weeks, beautifully produced
21 binders came out with about 80 proposals.
22 People had submitted hundreds of proposals,
23 but the ones that made it into the package
24 were chosen behind closed doors by executive

1 branch staff.
2 That package was presented to the MRT
3 meeting and approved on the spot. Within a
4 few days, dozens of pages of carefully
5 drafted bill text appeared and became
6 amendments to the Article VII bill.
7 The rhetoric was that the MRT package
8 came together in a wonderful process of
9 public input. Any serious observer would
10 have understood that almost the entire
11 package had actually been worked out weeks
12 before, behind closed doors, by the incoming
13 administration, working with a selected group
14 of interest groups, and the whole MRT process
15 was just political theater.
16 My first question is, why would anyone
17 believe MRT II will be any different?
18 COMMISSIONER ZUCKER: I'll start by
19 saying that MRT I came together, I think that
20 we all would agree that it was successful in
21 what its mission was to achieve. And I do
22 believe that as we move forward with MRT II,
23 there will be collaboration and communication
24 with all the, as I mentioned before,

1 stakeholders to achieve the goals of
2 addressing the changing landscape that has
3 happened since 2011 to 2020.
4 And I think that if there are specific
5 concerns, we will clearly address them. And
6 if there are things that you felt could have
7 been done differently the first time around,
8 as some of the things you mentioned here, I'm
9 sure that that will be entertained as we move
10 forward.
11 Donna, do you want to --
12 MEDICAID DIRECTOR FRESCATORE: No, I
13 don't have anything to add. But we hear
14 those concerns, and it is our intent to have
15 full participation of all of the members of
16 the MRT, including the legislative
17 representatives, that we expect -- fully
18 expect will be part of our discussion.
19 ASSEMBLYMAN GOTTFRIED: But the
20 question I asked was is the cake batter not
21 only all mixed, but it's been in the oven and
22 we're now putting the icing on it before the
23 MRT has even been named?
24 And I'm -- I don't think any serious

1 observer could doubt that that was the
2 process in 2011, and I see no reason to doubt
3 that that's not the process this year.
4 COMMISSIONER ZUCKER: We are working
5 on identifying the members of the MRT II.
6 And obviously when everyone's -- the
7 committee is formed, then they will come
8 together to discuss many of the issues that
9 have been raised.
10 And, you know, we have nine years
11 worth of time behind us now regarding many of
12 the challenges that the state has faced, and
13 we will move forward from there. And as I
14 said before, that that was the goal initially
15 in 2011, to move forward, address the un --
16 the incredible increase in costs to Medicaid.
17 The Governor and the team tackled that at
18 that time, moved forward. I think that was a
19 success on MRT I. As I mentioned before,
20 things have changed. We'll tackle it again.
21 ASSEMBLYMAN GOTTFRIED: Okay, the
22 administration has invented the slogan "blank
23 check syndrome" to blame New York City and
24 counties for much of the growth in Medicaid

1 spending and to justify imposing hefty
2 financial penalties on them. But my
3 understanding is that those local governments
4 only approve the enrollment of a portion of
5 Medicaid enrollees following federal and
6 state rules. DOH and DOH's Medicaid
7 inspector general can audit all of that and
8 can overturn any inappropriate enrollment.
9 The city and counties have no say in which
10 services an enrollee receives or how much of
11 that service, such as hours of home care, the
12 enrollee receives or how much providers are
13 paid.
14 All those determinations are made by
15 DOH or by Medicaid managed-care plans and
16 managed long-term-care plans under rules set
17 by DOH. And a lot of very knowledgeable
18 people tell me the same thing.
19 So my second question is, how can the
20 administration justify imposing hefty
21 financial penalties on the city and counties
22 for actions they don't do and have no control
23 over?
24 MEDICAID DIRECTOR FRESCATORE: So if

1 Dr. Zucker would like, I can respond to it.
2 Again, what these proposals are intended to
3 do is create a partnership with the local
4 districts, which share in the administration
5 of the Medicaid program. I already talked
6 about the 47 percent of applications for
7 Medicaid eligibility that the local districts
8 process. Those are, you know, complicated
9 applications. I listed off the types of
10 applications in response to Senator Rivera.
11 But there's one other very important
12 role that the districts play, and that is in
13 actually managing care for people who remain
14 in the Medicaid fee-for-service program. I
15 just wanted to put some of the facts out
16 there, and statistics, about that.
17 So persons who are in fee-for-service
18 and need long-term-care services and either
19 they aren't eligible to join a managed
20 long-term-care plan or they need short
21 duration services, that care is managed
22 and -- that care is managed by the local
23 district. The local district gets the
24 request, they do a nursing assessment, they

1 do a social assessment of the individual in
2 their home, they determine the plan of care.
3 And in fact, statewide there's about
4 907,000 or so people in the Medicaid
5 fee-for-service program where the local
6 district is managing just that personal care
7 and the long-term-care services, so
8 specifically the personal care services and
9 consumer-directed.
10 They approve, at the district level,
11 about 2.2 million hours of care every month
12 at a monthly cost of about $1.3 billion. So
13 as a matter of fact, I would submit the local
14 districts have a very active and ongoing role
15 in determining not just the 47 percent of the
16 people and whether they're Medicaid eligible,
17 but what services they get. And as we know
18 from the data that we've looked at and we've
19 all seen over time, a particularly important
20 role in the long-term-care-service approval
21 space, which is the fastest-growing component
22 of Medicaid spending.
23 There's additionally some other
24 activities that the local districts do around

1 some special populations that, you know, are
2 not as significant in terms of members and
3 dollars as long-term care, and they have a
4 role in investigating consumer waste, fraud
5 or abuse as well.
6 ASSEMBLYMAN GOTTFRIED: Well, I would
7 ask, when you use language like "blank check
8 syndrome" -- and, you know, I never went to
9 medical school, but I think "syndrome"
10 implies some kind of sickness. That
11 implies -- more than implies that something
12 bad is going on, that local governments don't
13 really care, and so they're handing out
14 Medicaid enrollment just willy-nilly to --
15 you know, like candy.
16 Is there any shred of evidence of that
17 kind of misconduct? Does the -- has the
18 department had to like put on extra staff to
19 revoke a lot of those enrollments because you
20 find that they're unjustified? I think I
21 know the answer to that question. But is
22 there any evidence that localities are doing
23 something wrong in this process and therefore
24 need to be slapped down?

1 MEDICAID DIRECTOR FRESCATORE: So I
2 would defer the definition of "syndrome" to
3 our health commissioner, my favorite doctor.
4 But on the other matter, this isn't --
5 this isn't an allegation about the districts
6 doing anything wrong. This is just the facts
7 around the responsibilities that local
8 districts have for administering Medicaid and
9 our desire to bring them back to the table,
10 work with them to align incentives with
11 growing costs. And we have certainly had
12 districts that come to us with ideas, whether
13 it's about improving eligibility processes,
14 using new databases to make certain people
15 don't have income they have not disclosed,
16 about novel ways to put care plans in
17 place that work for consumers and save -- you
18 know, efficiently use Medicaid dollars.
19 That's what this is about. This isn't
20 about placing blame. Frankly, we could all
21 go through audit reports and findings and
22 find someone somewhere who had some role in
23 administering the Medicaid program made an
24 error. But that's not what this is about.

1 This is about partnering to, once again,
2 bring the growth in the program into an
3 allowable tolerance so it's sustainable for
4 everyone.
5 ASSEMBLYMAN GOTTFRIED: Okay, we'll --
6 we may come back to this.
7 CHAIRWOMAN WEINSTEIN: Senate.
8 CHAIRWOMAN KRUEGER: Thank you.
9 Senate Finance Ranker James Seward.
10 SENATOR SEWARD: Thank you, Madam
11 Chair, Commissioner and Ms. Frescatore.
12 Just for the record, I just want to
13 say that I share some of the concerns that
14 have been expressed by the two chairs already
15 this morning in terms of MRT II. There's an
16 extremely limited time frame involved here,
17 and a huge job and responsibility and
18 challenge. And I do have concerns about the
19 necessary transparency and legislative input
20 through the process as well as the
21 participation of consumers and other health
22 advocacy groups and providers, other
23 stakeholders, in the deliberations of MRT II.
24 With that thought in mind, in the

1 first MRT process EMS did not have a seat at
2 the table. And EMS has emerged as a critical
3 component of the healthcare continuum.
4 There's a lot that goes on in that ambulance
5 on the way to the hospital or another
6 provider.
7 And my question is, will EMS have
8 representation on MRT II? I think it's
9 critically important that they do.
10 COMMISSIONER ZUCKER: So as I
11 mentioned before, all the stakeholders that
12 need to be involved will get involved on
13 MRT II. And I echo your words about EMS and
14 the unbelievable amount of effort and the
15 millions of individuals who utilize those
16 services.
17 And I will be the first to admit that
18 some loved one in my own family this year
19 used EMS in an emergency. And I realize what
20 goes on in the back of those ambulances, both
21 as a professional as well as a relative this
22 past year.
23 So we will make sure all of the
24 stakeholders are there. And as I said,

1 things have changed, the landscape has
2 changed. We will rise to the occasion again
3 and address it as needed.
4 SENATOR SEWARD: Thank you. I hope
5 you'll follow through on that because it's
6 lifesaving and life-enhancing what goes on in
7 that ambulance. And they should be at the
8 table.
9 I wanted to shift gears on the
10 additional surcharge on the Certificate of
11 Need, the 3 percent that was included in the
12 Governor's budget. How many CON applications
13 does DOH process annually? And is -- I have
14 concerns that by simply adding another
15 surcharge on the CON applications that those
16 costs will simply be passed down to consumers
17 and exacerbate the already high healthcare
18 costs.
19 COMMISSIONER ZUCKER: So I can't give
20 you the answer of how many, but I can tell
21 you it is an enormous amount, because every
22 month when we meet before the PHHPC committee
23 and I go through and hear about all the
24 Certificate of Needs, they are quite

1 expansive.
2 I will say there will be the
3 exception -- be the opportunity to have
4 exceptions for those Certificate of Need
5 applications as we move forward. Also I will
6 mention that just the complexity and the
7 volume of those Certificate of Needs has
8 increased over the course of -- at least
9 during the six years I've been in this role.
10 SENATOR SEWARD: Do you have concerns
11 that the estimated $70 million in revenue
12 from this new surcharge will be $70 million
13 of additional costs for the healthcare
14 system?
15 COMMISSIONER ZUCKER: Right, it
16 will -- that will be -- it's not going to --
17 it's going to help the system in general, in
18 the big picture. So I am confident that's
19 where it will go.
20 SENATOR SEWARD: You're saying the
21 surcharge will help the system?
22 COMMISSIONER ZUCKER: Well, I'm saying
23 the surcharge will be -- I mean, this is some
24 of the resources that we need to move things

1 forward. But overall, it helps the system in
2 an effort to try to provide the amount of --
3 the complexity of these applications and to
4 move them through faster and quicker.
5 Because we've heard a lot of people asking,
6 saying, Well, I still haven't received my
7 Certificate of Need. And so we try and move
8 the system to make it more seamless.
9 SENATOR SEWARD: I would just
10 reiterate, my concern is that the $70 million
11 will be passed on to healthcare consumers,
12 and that concerns me.
13 My final question has to do with the
14 Rural Health Program consolidation that's
15 part of the budget. This is not a lot of
16 money, but it's critically important to the
17 rural areas, consolidating the Rural
18 Healthcare Access Development Program and the
19 Rural Healthcare Network Development into one
20 program with a 25 percent cut.
21 What's the rationale for eliminating
22 these important programs in high-need rural
23 areas of our state?
24 COMMISSIONER ZUCKER: Well, I don't

1 feel that we are eliminating -- that we're
2 not interested in the issue of rural health;
3 in fact, that we have made an incredible
4 commitment on this issue, particularly in the
5 North Country. I can tell that we are
6 working diligently to try to sort that out.
7 And we are also aware of the
8 challenges in rural health, which is a way
9 different -- many different issues,
10 particularly when it comes to travel,
11 distance, EMS, that you just brought up
12 before. And we're trying to figure out ways
13 to help all people in the state, particularly
14 those in the rural area.
15 SENATOR SEWARD: Thank you. My time
16 is up.
17 CHAIRWOMAN KRUEGER: Thank you.
18 Assembly.
19 CHAIRWOMAN WEINSTEIN: We've been
20 joined by Assemblywoman Fahy, Assemblywoman
21 Solages, Assemblyman Jacobson, and we go to
22 Assemblywoman Bichotte.
23 ASSEMBLYWOMAN BICHOTTE: Thank you,
24 Commissioner. Thank you, both of you, for

1 being here today. Some of the questions that
2 I'm going to be asking were probably asked
3 earlier, but my constituents would like to
4 hear just a brief answer to these questions.
5 The first question -- the first couple
6 of questions is the budget asks the local
7 municipalities to contribute more money
8 towards Medicaid. However, it does not give
9 the local municipalities more control over
10 what the providers can charge, which services
11 they deem unnecessary or duplicative. The
12 question is, how can you hold me, let's say,
13 the local, responsible for something without
14 giving me control of the spending? It's like
15 saying, I'll take your credit card and spend
16 how I wish, but don't tell me what to do with
17 it. So that's an issue.
18 And part two of that is with the
19 Medicaid Redesign Team, we talked about who
20 we would like to be part of that. In terms
21 of groups, do you have a sense of what groups
22 will be part that? For example, like nursing
23 homes, hospitals, home care agencies,
24 ambulance -- I heard it earlier, EMS is very

1 important. That's very important to me as
2 well -- unions, large unions like 1199 and
3 NYSNA. What kind of groups are you thinking
4 to be part of the MRT? Again, this is high
5 level.
6 COMMISSIONER ZUCKER: So I'm going to
7 address the second question, and Donna, you
8 can address the issue on local share.
9 I will tell you that since 2011, the
10 challenges that the state has faced on
11 certain issues of healthcare have changed.
12 Long-term care has increased significantly.
13 The aging population of the state has also
14 gone up in percentage. And we recognize that
15 when we move forward on the issues of MRT II,
16 that those who represent those interests will
17 need to be part of the mix.
18 In addition to that, in 2011 people
19 were -- the amount of home care was
20 different. The nursing home issues were
21 different. It was a completely different, as
22 I mentioned before, landscape at that time.
23 So when we move forward with MRT II,
24 we'll make sure that those who have an

1 interest in those particular challenges that
2 we face as a state will be represented, to be
3 sure that the next plan moving forward
4 addresses their needs.
5 And on the local share, did you want
6 to comment?
7 MEDICAID DIRECTOR FRESCATORE: Yeah, I
8 think I -- I don't want to take time if you
9 feel it's already been answered. But we
10 talked about the 47 percent of the
11 applications that are processed by the
12 district just in home care services, personal
13 care services specifically, and consumer
14 directed. That about 900,000 people who
15 remain in the fee-for-service program have
16 care plans developed by the local district.
17 The regulation, if you're going to
18 look at the personal care regulations and the
19 consumer-directed program regulations,
20 they're very clear about the local district's
21 role, which is to do the assessment and
22 develop the care plan, if there's a
23 disagreement, represent the Medicaid program
24 at a fair hearing to defend the decisions

1 they've made.
2 Again, the local districts taken
3 collectively, just on that service, approve
4 about 2.2 million hours of care per month at
5 a cost of about 1.3 billion a month. So
6 times 12, that gives you an idea of -- just
7 for those services.
8 So -- and there are some places -- to
9 address your specific question,
10 Assemblywoman, there are some limited places
11 where the reimbursement rate is also set by
12 the local district, most notably New York
13 City, for personal care and consumer-directed
14 services. That reimbursement rate is set by
15 the city. For many, many years that's been
16 in place; not something new.
17 ASSEMBLYWOMAN BICHOTTE: Well, thank
18 you. And I will follow up more on details.
19 I do have limited time, so I have a
20 few questions that I'm just going to bundle.
21 When it comes to maternal mortality,
22 thank you for addressing that in your
23 briefing. I just want to know like who's
24 getting the contracts for maternal mortality

1 training.
2 Also just, you know, I am a victim of,
3 you know, having to lose my baby. I almost
4 died. And I notice that one of your board
5 members was actually the supervising doctor
6 of the doctor who turned me away when my baby
7 was protruding out, from Columbia Hospital.
8 I'm requesting that they do not represent on
9 the board.
10 And I want to assure that we need to
11 look at the discrimination against black and
12 Latino pregnant women.
13 The next thing I quickly want to touch
14 base on is tobacco. I know you talked about
15 the flavored e-vaping. We certainly want to
16 also address the flavored tobacco that also
17 have been racially targeting communities of
18 color. And if we take away the flavored
19 e-vaping, our kids are now going to go to
20 flavored tobacco. We're not taking tobacco
21 away, we're just taking the flavored part,
22 and we need people to know that. And we're
23 hoping the state is not being bought by the
24 Big Tobacco, R.J. Reynolds.

1 COMMISSIONER ZUCKER: So I'll -- can
2 I --
3 CHAIRWOMAN WEINSTEIN: Sure.
4 COMMISSIONER ZUCKER: -- respond?
5 So a couple of things, one on the
6 maternal mortality. I remember your story
7 last year, and I have actually shared it with
8 others and have opportunity to share a story
9 also, not right now, but with you, about some
10 of these issues on maternal mortality.
11 The state is very, very committed to
12 this issue, as you know, and we will
13 continue. We're moving forward with the
14 issues of the review board and many of the
15 other challenges that we heard as a result of
16 the listening sessions that we did last year.
17 And the Governor is committed to this issue.
18 The department has been moving forward on
19 this. So rest assured that this is not
20 something which was just a series of meetings
21 and that we're not moving forward. We
22 continue to meet and we continue to implement
23 the charge that the Governor gave us.
24 On the issue of tobacco and

1 particularly vaping, this has been a
2 challenge. When we sat here last year, this
3 was not something which was even on the
4 radar. And we have, you know, 126 cases of
5 vaping-related illnesses in the State of
6 New York. Unfortunately, we've had four
7 deaths. And so the Governor has asked that
8 we take this on and address it, and we will,
9 to make sure that we do not create a next
10 generation of individuals addicted to
11 nicotine. So we'll move forward on that as
12 well.
13 CHAIRWOMAN WEINSTEIN: Thank you.
14 Senate.
15 CHAIRWOMAN KRUEGER: Thank you.
16 Our next questioner is Senator John
17 Liu.
18 SENATOR LIU: Thank you, Madam Chair.
19 Thank you, Commissioner, for joining
20 us today.
21 I do want to follow up a little bit on
22 the questions that my colleagues have asked
23 already, which is pertaining to the 3 percent
24 growth in Medicaid spending that now local

1 governments are going to be responsible for,
2 according to the Governor's proposal. Is
3 there already an idea which counties will
4 likely exceed that 3 percent cap?
5 COMMISSIONER ZUCKER: We don't know
6 that yet.
7 SENATOR LIU: You have no idea.
8 MEDICAID DIRECTOR FRESCATORE: No,
9 I -- we don't -- I don't have that
10 information.
11 Just as a clarification, counties that
12 are within the property tax cap and within
13 the 3 percent won't be picking up any
14 additional funds. So the proposal as it's
15 made is that if the locality grows their
16 property tax by more than 2 percent, then
17 they would pay the increase year to year in
18 Medicaid costs.
19 But if the county, conversely, is
20 within the property tax cap and within the 3
21 percent, which many counties will be, that
22 there's a new opportunity in effect to share
23 savings, which they don't have currently.
24 SENATOR LIU: What about counties that

1 don't have the 2 percent cap on property tax
2 increases?
3 MEDICAID DIRECTOR FRESCATORE: The
4 counties that don't -- whose tax cap -- taxes
5 grow more than 2 percent would be responsible
6 for the growth in Medicaid.
7 SENATOR LIU: And what's been the
8 Medicaid growth in the last couple of years
9 statewide?
10 MEDICAID DIRECTOR FRESCATORE: So the
11 growth statewide for -- you know, if we look
12 at year over year, has remained about
13 2.2 percent for a number of years running.
14 In more recent years, more notably this past
15 year, the increase in spending for a number
16 of reasons that I think we've discussed, and
17 we're happy to talk about here if it's of
18 interest, has exceeded the global cap. But,
19 you know --
20 SENATOR LIU: Has exceeded what? I'm
21 sorry, has exceeded --
22 MEDICAID DIRECTOR FRESCATORE:
23 Exceeded the 3 percent global cap. For a
24 number of reasons, including --

1 SENATOR LIU: So last year the -- so
2 last year the growth exceeded 3 percent. And
3 the year before?
4 MEDICAID DIRECTOR FRESCATORE: It
5 would have -- I mean, it has varied from year
6 to year. On average, over the last several
7 years, it has been 2.2 percent growth year
8 over year.
9 In last state fiscal year, in order to
10 keep the spending within the 3 percent, which
11 is this 10-year rolling average of CPI, it
12 was necessary to take some administrative
13 actions to not exceed the cap. But generally
14 if we look since the MRT, the spending has
15 remained within the global cap in aggregate.
16 SENATOR LIU: So you're saying that
17 it's reasonable to expect that Medicaid, with
18 all these controls that will be implemented,
19 will be contained within a 3 percent growth
20 rate from this year to next year?
21 MEDICAID DIRECTOR FRESCATORE: We
22 believe that with the actions that are
23 proposed and the reconvening of the Medicaid
24 Redesign Team process, that just as we have

1 proven we've been able to do before, that we
2 can find ways without impacting benefits or
3 local governments to stay within the spending
4 cap.
5 SENATOR LIU: So what can a local
6 government -- give me an example of what a
7 local government can do to contain their
8 growth of Medicaid spending. This is in line
9 with what our Assembly chairs already talked
10 about.
11 MEDICAID DIRECTOR FRESCATORE: And so
12 I've given some examples before --
13 SENATOR LIU: Just one.
14 MEDICAID DIRECTOR FRESCATORE: Well,
15 I -- certainly, you know, some districts, for
16 example --
17 SENATOR LIU: Deny benefits to people
18 who need it?
19 MEDICAID DIRECTOR FRESCATORE: No.
20 No. That would not be on our list. But we
21 don't think it would be on theirs.
22 SENATOR LIU: Well, give us an
23 example. What could a local government --
24 MEDICAID DIRECTOR FRESCATORE: So I

1 provided two examples before, I'll just say
2 them both again, which -- Senator, we know
3 that some local districts have found ways to
4 better identify assets or resources that
5 individuals have when they apply. That is a
6 good -- that's good program integrity, that
7 is good administration of the program.
8 And we also know that there are some
9 districts who have found, you know, and work
10 at very innovative ways to develop care plans
11 that are very, you know, efficient for
12 consumers when the local district is
13 responsible for the care. So we --
14 SENATOR LIU: So go after assets.
15 MEDICAID DIRECTOR FRESCATORE: Pardon
16 me?
17 SENATOR LIU: Go after assets.
18 MEDICAID DIRECTOR FRESCATORE: No.
19 Just be certain that any resource or asset
20 that should be counted in the Medicaid
21 application is identified. Not go after
22 assets.
23 But the population for which the local
24 districts make determinations generally have

1 both resource tests and look-back tests in
2 certain instances.
3 SENATOR LIU: All right, thank you.
4 In my final time, let me ask the
5 commissioner about how the state is staying
6 ahead of the curve on the novel coronavirus.
7 COMMISSIONER ZUCKER: Sure.
8 SENATOR LIU: You state in your
9 testimony that we're ahead, that in fact your
10 department identified this as a potential
11 coronavirus while the rest of the world was
12 still terming it some kind of mysterious
13 disease.
14 COMMISSIONER ZUCKER: Well, we --
15 first of all, we have -- I will say that we
16 have an incredible lab, the Wadsworth Lab,
17 and the ability to identify and figure out
18 problems ahead of time. That's in the big
19 picture.
20 How are we staying ahead? We --
21 initially when this was a handful of cases
22 that were reported in the news from Wuhan, we
23 were -- already internally said there is the
24 potential that this could spread. We jumped

1 on this immediately to figure out what we
2 need to do, knowing that New York is an
3 international center, both downstate and
4 upstate. And we realized that we need to
5 figure out what we would need to do.
6 SENATOR LIU: And what should
7 New Yorkers do? Because there have been so
8 many events that have already been canceled.
9 What should New Yorkers do? Should they stay
10 home?
11 COMMISSIONER ZUCKER: Well, I think
12 the number-one thing to do is use really good
13 common sense. You know, if you're sick, stay
14 home, as you would do if you had the flu. I
15 would not recommend anyone with a flu or a
16 cold expose others to that potential virus
17 that they have, whether it's coronavirus
18 that's the one from Wuhan or a coronavirus
19 that gives you a cold or a flu that we have
20 in the -- this season.
21 I will say that we have had 58,000
22 cases of flu in the State of New York so far
23 this year -- 57,000, 58,000. We will give
24 you the same recommendations about

1 coronavirus that we give about flu, is that
2 if you're ill, call your doctor. You know,
3 limit your exposure to other individuals.
4 We're learning a lot about this virus
5 right now, and it's -- there is a lot of
6 information out there, unfortunately and
7 fortunately. Unfortunately, the power of the
8 internet is -- has an advantage because you
9 get information out quickly, and it has a
10 disadvantage because misinformation can also
11 get out.
12 So my advice to everyone is to use
13 good common sense, and if you -- wash your
14 hands and do all the same things that we tell
15 everyone to do when it comes to a cold or flu
16 season.
17 Right now there are over 5,000 cases
18 in China, there are five cases here in the
19 United States. We are tracking this. New
20 York State has had 11 persons of interest;
21 seven of them have come back negative. We're
22 still waiting to hear about the other four.
23 We have put signs and posters out there.
24 We're working with the Port Authority,

1 working with the MTA down in the city. We
2 are working with our hospital associations
3 and nursing associations, the physicians.
4 And we're on the forefront of this. And we
5 will -- like we do with every other issue, we
6 will tackle this. We tackled this when it
7 came to the measles outbreak, we tackled this
8 when it came to flu, vaping issues, and I can
9 go down the list of so many other things that
10 we've had over the course of at least during
11 my time in this seat. And we will do it
12 again. New York State always leads, and we
13 will lead on this.
14 SENATOR LIU: Thank you for staying on
15 the forefront.
16 CHAIRWOMAN KRUEGER: Thank you. No,
17 sorry, Senator, we're going to cut you off.
18 Thank you for the PSA on public health
19 practice --
20 (Laughter.)
21 CHAIRWOMAN KRUEGER: -- for new
22 viruses we may or may not be facing here at
23 home.
24 The Assembly.

1 CHAIRWOMAN WEINSTEIN: We go to
2 Assemblyman Cahill, chair of our Insurance
3 Committee.
4 ASSEMBLYMAN CAHILL: Thank you.
5 Dr. Zucker, your wonderful uplifting opening
6 about measles and vaping deaths and
7 coronavirus and Zika and Ebola and hepatitis
8 and contaminated water and cancer makes me
9 know why you were here early. You are the
10 only person for whom a joint legislative
11 hearing is the best part of your year.
12 (Laughter.)
13 ASSEMBLYMAN CAHILL: So I want to talk
14 to you about early childhood intervention.
15 But before I do, I just have a suggestion on
16 the MRT front. We heard the Governor's
17 speech and, you know, using just reductive
18 logic of where we're going to find our
19 savings with healthcare and particularly
20 Medicaid, he said it's not going to be the
21 beneficiaries, it's not going to be the
22 localities. That only leaves a couple of
23 places left.
24 I think it would be beneficial if

1 before even the panel was fully convened, if
2 the range of options were talked about
3 publicly so that there could be a real
4 serious public discussion about what is and
5 is not possible.
6 On to the area of early childhood
7 intervention. Is the state still using a
8 fiscal agent?
9 COMMISSIONER ZUCKER: We have a fiscal
10 agent. And I know there's concerns, but they
11 have been effective in what they're doing.
12 And I know we've had this conversation a
13 little bit about this.
14 ASSEMBLYMAN CAHILL: Yeah, we've had
15 this conversation, and also with -- I think
16 maybe even with your predecessors, over the
17 fiscal agent, because it's been going on for
18 over five years. And to my recollection, the
19 participation of insurance companies has not
20 increased over the course of that time, and
21 several tens of millions of dollars have been
22 given to the fiscal agent to make that
23 happen.
24 Is there still a bonusing structure in

1 place for the fiscal agent?
2 COMMISSIONER ZUCKER: I have to check
3 on that.
4 ASSEMBLYMAN CAHILL: Okay, if you can
5 get back to me on that, I'd appreciate it.
6 Under the new proposal that the
7 Governor has offered, pay and pursue, what
8 will the role of the fiscal agent be?
9 COMMISSIONER ZUCKER: Well, on the new
10 proposals there's issues of billing codes,
11 which you've heard, about trying to make the
12 billing codes tighter and make sure the EI
13 providers can consolidate those codes. So
14 that's one issue.
15 There are other issues regarding
16 written orders for the EI evaluations and
17 therapy services, which is also helpful. And
18 there's also we'll try to allow more
19 therapists, we'll try to make sure that some
20 of the plans that don't have therapists for
21 Early Intervention will. That will be sort
22 of something which we'll incorporate into
23 that.
24 The tie of -- how this ties back to

1 the fiscal agents, you know, I can get back
2 to you on the details. But this is a
3 partnership in trying to move this forward,
4 and I know there's been concerns of why --
5 the role of the fiscal agent on this as well.
6 But we have collected, they have
7 collected a lot more than --
8 ASSEMBLYMAN CAHILL: That's not what
9 the statistics seem to prove. The statistics
10 seem to prove we're kind of stuck in the same
11 single-digit, low-single-digit recovery from
12 insurance companies that we were in before we
13 paid them 40, 50, 60, 70 million dollars.
14 Again, there's a proposal to continue
15 this sort of three-way division of
16 responsibility or four-way division of
17 responsibility. There's the fiscal agent has
18 some responsibility, the insurance companies
19 have some responsibilities, local and state
20 government have some responsibilities. But
21 still a significant burden is being placed on
22 the shoulders of folks who are making maybe
23 $25 an hour for providing services to the
24 most vulnerable kids in our population. And

1 they're not being compensated for their time
2 when it comes to collecting their just
3 compensation.
4 Isn't there a better way? Isn't there
5 a way where we can say, okay, here's what the
6 insurance companies are really responsible
7 for, here's what we are responsible for, and
8 just come up with a means of saying, you
9 know, Okay, insurance companies, write us a
10 check for this amount of money so we can fill
11 the hole in the budget, get rid of this
12 fiscal agent person, and save a couple of
13 tens of millions of dollars there and let
14 providers provide the services that they're
15 intended to provide?
16 COMMISSIONER ZUCKER: Well, on one of
17 the issues of the provider, one of the
18 proposals is also to have the provider get
19 paid from the insurer and then the insurer
20 have to try to appeal to get the money back
21 from them, right, so that they can at least
22 get --
23 ASSEMBLYMAN CAHILL: And I get that.
24 But I'm a little concerned with a provider

1 not making a lot of money -- a lot of single
2 moms in this business -- then finding out two
3 months later that the payment that the
4 insurance company gave them, they have to
5 give back. I mean, they probably already
6 paid the rent or the car payment or the water
7 bill with that money. So I don't know how
8 this fixes the problem.
9 COMMISSIONER ZUCKER: Right. But
10 hopefully the recognition is that they are
11 not going to get that -- the provider will
12 maintain that money and the insurance company
13 will not -- or the insurer will not be able
14 to pull that back.
15 ASSEMBLYMAN CAHILL: But that's
16 hopefully. That's not realistic. Because,
17 you know, if it's not a covered benefit and
18 the benefit has been paid for, the insurance
19 company will rightly recover it.
20 I won't dwell on this any longer, but
21 I would suggest that we seriously consider
22 revamping this system from soup to nuts. I
23 think the time has come. I think the
24 experiment with the fiscal agent has proven

1 to be a failure and it's time for us to
2 really get our arms around this so that we
3 can get back to the provision of services for
4 children as being the focus of this program.
5 COMMISSIONER ZUCKER: You know, I know
6 you're out of time, but I will just say that
7 when I was preparing, looking at some of the
8 materials, I was also saying to myself maybe
9 at some point we could just sit down, not in
10 this forum, and just hash out some of these
11 challenges. You know, a handful of us -- my
12 experts on the team and your team -- to go
13 through it.
14 That would be helpful, and I'll be
15 involved in that. Thanks.
16 CHAIRWOMAN WEINSTEIN: Thank you.
17 We've been joined by Assemblyman
18 McDonald.
19 And now to the Senate.
20 CHAIRWOMAN KRUEGER: Thank you.
21
22
23
24

1 We've been joined by Anna Kaplan, and
2 our next questioner is Todd Kaminsky.
3 SENATOR KAMINSKY: Hello, Doctor.
4 COMMISSIONER ZUCKER: How are you?
5 SENATOR KAMINSKY: I'd like to ask you
6 a question about the Supplemental Food
7 Assistance Program. Right now on Long Island
8 there is a gap with the program that's
9 incredibly important to many people -- 50,000
10 Long Islanders are supposed to receive
11 supplemental food assistance and, because of
12 the way the bidding process was, there's
13 right now no -- there's no person that is
14 meant or no organization that is meant to
15 serve those individuals.
16 Now, while a stopgap measure was put
17 in place, which is appreciated, that's due to
18 expire the end of March, and right now
19 there's no provision to have more
20 supplemental food, which our seniors,
21 especially, and families rely on.
22 So I'd like to read you a letter I
23 received from a woman named Barbara at the
24 Long Beach Housing Authority, which I think

1 really gets at the issue. Barbara writes:
2 "I've been getting meals from this program
3 for the past eight years. I get meals two or
4 three times a month, and it was good food.
5 I'd get cereal and milk -- the really good
6 kind of milk, too -- sometimes chicken or
7 fish, and I just had to stick them in the
8 microwave. A lot of seniors in my building
9 do not get food stamps, and they're
10 struggling to get food. The seniors that do
11 get food stamps get about $16 a month, and it
12 is not enough to buy food. We relied heavily
13 on this program, and now it has been taken
14 from us and we get nothing. The state needs
15 to do something and to help seniors."
16 I have many such letters, and I have
17 trouble believing that our state, in light of
18 being in the wealthiest country in the world,
19 in a wealthy state with a budget in the tens
20 of billions of dollars, well north of
21 $100 billion, that we're not able to do
22 something to guarantee that 50,000
23 Long Islanders who until recently received
24 supplemental food assistance, can't still get

1 it. And I'm hoping we could fix that.
2 COMMISSIONER ZUCKER: So let me
3 address that.
4 And first I agree with you, the state
5 is committed to the aging population. We are
6 the first age-friendly state in the nation.
7 As you probably have heard me say, that this
8 is one of the issues that I have asked the
9 department to work heavily on regarding the
10 needs of the seniors in the State of
11 New York.
12 DOH has funded and has executed two
13 emergency contracts to transition seniors to
14 other food service -- food access programs on
15 Long Island, so we're working on that as
16 well. We did extend the contract initially
17 on that issue.
18 We're also working for a longer-term
19 plan for this issue. We're working with our
20 partners like SOFA to explore what other
21 options are there.
22 I recognize the concerns, and I assure
23 you that we will do everything to make sure
24 that food and nutrition is available to

1 those -- whether it's through this kind of
2 program or another program that will help
3 them. So I hear what you say, I hear the
4 words of your constituent, as well as others
5 who have spoken about this.
6 SENATOR KAMINSKY: Can I tell the
7 seniors that I'm talking to that by April 1
8 of this year there will be the same
9 supplemental food that they've been relying
10 on?
11 COMMISSIONER ZUCKER: I'm going to
12 work -- well, I don't want to commit to that
13 particular contract or plan, but we will work
14 to make sure that there is -- the needs --
15 their needs are met. I think that's about
16 what --
17 SENATOR KAMINSKY: You can understand
18 it's a very difficult conversation to tell
19 someone that because the RFP process went
20 screwy, there's no provider here, so we'll
21 figure it out. I mean, this is -- this is
22 very critical. So I really am counting on
23 your partnership in getting this done in the
24 budget this year.

1 COMMISSIONER ZUCKER: I hear you. I
2 hear that from their perspective there's a
3 bureaucracy of -- sort of that didn't work
4 and someone didn't fill something out on
5 their end, and that we could not say
6 something ahead of time because that's not
7 within the way the laws are written of what
8 we're allowed to say and we had to wait until
9 we issued a contract to somebody.
10 But all that said, there's somebody on
11 the other end of this who needs their food,
12 and we will make sure that happens.
13 SENATOR KAMINSKY: Thank you.
14 I'd like to ask you about the study to
15 provide New York City water to Nassau County.
16 It's mentioned very descriptively, but then
17 there's -- I don't see and there's not money
18 actually funded for it in the budget.
19 Can you tell us if that money is going
20 to be available, how much you think it is,
21 and are you committed to seeing it through?
22 COMMISSIONER ZUCKER: So I can't give
23 you the amount -- you know, how much money
24 will be allocated to this. However, I will

1 tell you that DOH and DEC are working on
2 this. We recognize the interests of making
3 sure that there is water, the potentially
4 city water system goes out to Long Island.
5 The Governor has committed an
6 incredible amount of resources, in the
7 billions, for issues of drinking water
8 quality. We have a task force that is
9 chaired between Basil Seggos and myself. We
10 have been working on so many different areas,
11 whether it's 140-something different water
12 systems that we have addressed. I think that
13 this nation leads on this issue, and we will
14 lead on this as well. And I would challenge
15 anyone to tell me of any other state in this
16 nation that has not committed so much to the
17 issues of environment and water quality as we
18 have in the state under the Governor's
19 leadership.
20 SENATOR KAMINSKY: I appreciate that.
21 Lastly, what do you say to some CPA
22 firms who have been told they can no longer
23 certify cost reports and that the work will
24 be audited by KPMG on the back end? Many of

1 them have hired staff, they're ready to do
2 them, and they've just been told it's done.
3 Is there going to be any process for
4 addressing that?
5 MEDICAID DIRECTOR FRESCATORE: Yeah,
6 and we -- thank you. We became aware of this
7 concern I think just yesterday.
8 So we have developed a new cost report
9 consistent with state law that was enacted
10 for broadly home care providers, and in
11 being -- attempting to be flexible and
12 recognize, you know, the new cost reporting
13 structure and the administrative requirements
14 on the agencies, we removed the requirement
15 that the cost report be certified by a CPA.
16 This is the case currently with other
17 reports, including the hospital cost reports.
18 We didn't in any way intend to say to
19 an agency that a CPA shouldn't or can't help
20 them prepare it or submit it on their behalf.
21 It was just a matter of having, you know, a
22 separate certification.
23 We can clarify that if you think that
24 is helpful. And, you know, certainly

1 providers -- we want to give them the
2 flexibility to decide whether or not they
3 want that review done, even if it's not a
4 formal certification.
5 SENATOR KAMINSKY: Thank you.
6 CHAIRWOMAN KRUEGER: Assembly.
7 CHAIRWOMAN WEINSTEIN: We have been
8 joined by Assemblywoman Byrnes, Assemblywoman
9 Rosenthal. And we go to Assemblyman Byrne
10 for questions.
11 ASSEMBLYMAN BYRNE: Thank you,
12 Chairwoman. And thank you, Commissioner,
13 Dr. Zucker. And Director Frescatore, I want
14 to say thank you again for being here.
15 At the risk of being a little
16 redundant, I'm going to ask some questions
17 that are probably a little bit familiar to
18 what you've already heard from my colleagues.
19 And I know we're limited on time, so I'm
20 going to try to ask a few questions and then
21 give you some time to respond, if that's okay
22 with you.
23 My first question is, how are we in
24 this mess with the budget deficit? Because

1 when we were talking about the deficit early
2 on, reports were pointing to things like
3 increased costs for long-term care, the
4 minimum wage. And then more recently we're
5 hearing about things like local governments.
6 And I'd like to really drill down on why did
7 we get -- why has the cost of the program
8 grown. So what are we looking at
9 specifically? And when did we learn about
10 that? And when was that shared with the
11 Legislature, and why not sooner? Because one
12 question I'm eager to ask directly more to
13 you, Commissioner, is my understanding is
14 with the global cap, when that passed
15 initially, you do have some additional powers
16 to implement cost-cutting plans -- to see
17 what your thought process was and why you did
18 not do that. And then that's really more why
19 we're here with this deficit. I'd like to
20 hear your thoughts.
21 The MRT II plan, just to echo what my
22 colleagues have already said, certainly
23 transparency is a must. I would add balance.
24 People mentioned -- my colleagues mentioned

1 emergency service providers, EMS. Certainly
2 I would say all stakeholders, all providers,
3 home care, deserve a seat at that table.
4 And I would say the Legislature
5 deserves a seat at the table too. I believe
6 the last time majority/minority conferences
7 had some appointments. I would strongly urge
8 that we have a presence there, because I know
9 we'd like to talk in more detail. At this
10 hearing, it's a budget hearing. That at a
11 minimum, we should be present at the MRT II
12 as well.
13 And then finally, I did want to -- and
14 Commissioner, this may be a question that you
15 may end up referring to OASAS for another
16 public hearing later, but I still want to
17 bring it up. Because I believe last year we
18 passed the -- that opioid sales tax brings in
19 revenue to the state. And there's a growing
20 need for things like medication-assisted
21 treatment and access for MAT. And the
22 Governor did veto a bill earlier that would
23 have eliminated preauthorization for Medicaid
24 services. He didn't veto one for, I believe,

1 private plans.
2 But he says he wants to expand MAT and
3 make that a priority. Well, how much money
4 are we expanding for those services? And
5 that $100 million we're getting from the
6 opioid tax, is it going to help the people
7 that are suffering from addiction?
8 So I'll close with that, and then
9 maybe I'll follow up if there's time.
10 COMMISSIONER ZUCKER: Sure, let me see
11 if I can address some of this.
12 So I'm going to start on the issue of
13 your first question about how did we get
14 here. And I just wanted to share some
15 numbers. So when the Governor came in in
16 2011, we were at 13 percent Medicaid
17 spending. It was growing truly at an
18 unsustainable rate.
19 And since 2012, so just going from
20 there, one and a half million New Yorkers
21 have gained Medicaid. So that's a 32 percent
22 increase in Medicaid enrollment. We went
23 from 4.7 to 6.2 million people.
24 At the same time, the rate of

1 uninsured New Yorkers has declined. We are
2 -- right now we have 18 million people
3 covered. That's 95 percent, essentially
4 95 percent of the state. That's
5 unbelievable. That's excellent. All Funds
6 Medicaid spending has grown substantially
7 over the same period. So we went from
8 54 billion in 2012 to 77 billion. So that
9 was 2012 to 2020.
10 And now we're a decade later. Many
11 things have changed, as I mentioned a little
12 bit about the long-term care issues, the
13 costs, the aging population, many other
14 things. We've been challenged.
15 So overall healthcare costs have
16 increased, managed long-term care has gone
17 up. This increased minimum wage is another
18 issue that comes into play here. These are
19 just some of the things that we've had --
20 ASSEMBLYMAN BYRNE: So I'm sorry to
21 interrupt, only because I want you to
22 continue to answer the question. But so it
23 would be unfair, in your opinion, to point
24 this solely at local governments? You would

1 look at it as a totality of --
2 COMMISSIONER ZUCKER: There's
3 multiple, there's many factors.
4 ASSEMBLYMAN BYRNE: Okay, continue,
5 I'm sorry.
6 COMMISSIONER ZUCKER: I was going to
7 say local takeover, enrollment, there are
8 many different issues that are involved here,
9 and Donna can go through the details on all
10 of this as well on some of the different
11 parts here.
12 So this is a change in the landscape.
13 We, as I've mentioned, we will tackle it.
14 We've done it before. And that's why when
15 you ask about MRT II, we need to be sure that
16 all the individual stakeholders are involved.
17 The Legislature of course will be involved,
18 that they were involved in the MRT -- the
19 first one. And home care obviously are some
20 of the things that have changed, because
21 people are moving from the hospital into home
22 care, and it was different in 2011-2012. So
23 that's one issue.
24 Donna, do you want to add to that, and

1 then I can get back to the MRT.
2 MEDICAID DIRECTOR FRESCATORE: Yeah, I
3 think, Dr. Zucker, you covered all the major
4 points. We know that healthcare costs are
5 increasing more than the 3 percent allowance
6 in the global cap. In fact, the CMS office
7 of the actuary specific to Medicaid estimates
8 the cost growth nationally at about
9 5.5 percent.
10 So the cap, a very important tool.
11 And that's exactly what it is, in my view.
12 It's a tool for us all to monitor spending.
13 The reality of -- the amount of money we have
14 to spend is the reality. The global cap, to
15 me, is a tool by which we -- the metric by
16 which we all measure it. And certainly
17 something could be discussed in the MRT
18 process.
19 Managed long-term care has put a
20 tremendous amount of pressure -- with aging
21 demographics, we've seen a 301 percent
22 increase in the cost of the managed long-term
23 care program between 2013 and 2019. It now
24 accounts for 33 percent of total Medicaid

1 spending, just the managed long-term care
2 program.
3 Certainly the Medicaid cost of paying
4 minimum wage to healthcare workers has added
5 to spending. Thus far, the Medicaid global
6 cap has supported about $2.4 billion of
7 costs. We would argue very, very good
8 policy, but it does result in spending. We
9 expect that will grow to $1.8 billion in the
10 current year.
11 The enrollment, as Dr. Zucker
12 mentioned -- remember, the cap is aggregate,
13 it's not a per-person cap, so it absorbs
14 changes in enrollment. We had a tremendous,
15 you know, ability to reach people who were
16 already eligible for Medicaid, in large part,
17 but had not signed up. And so that put
18 pressure on the cap.
19 Certainly the policy decision to
20 freeze local contribution -- the Medicaid
21 global spending cap is looking at the state
22 spending, the state Department of Health
23 spending only -- contributed to the
24 structural deficit in the cap.

1 And then additionally and importantly,
2 from our perspective, support for distressed
3 hospitals, through operating assistance that
4 totals probably about $800 million a year
5 that counts towards the cap.
6 You know, I think all kind of a long
7 way of saying that these things came
8 together. And in March of last year -- we
9 had been watching the trends through the
10 fall. In March of last year we realized that
11 certain anticipated things weren't going to
12 happen, that the growth in managed long-term
13 care was going to be sustained, that it
14 wasn't kind of a one-time increase.
15 We also were not able, due to various
16 reasons, including delays in federal
17 approval, to implement some of the savings
18 options that had been enacted in prior years'
19 budgets. And we needed to take an action.
20 And with the administrative authority of the
21 commissioners, we looked at a range of
22 different options and concluded that the
23 option that would result in the least
24 disruption -- I would argue virtually no

1 disruption -- to consumers or their access or
2 quality of care, would be to defer by three
3 days a last cycle of payment to the managed
4 care plans. And that was about -- that was
5 the majority of the $1.7 billion deferral --
6 ASSEMBLYMAN BYRNE: Into the next
7 fiscal year.
8 CHAIRWOMAN KRUEGER: We're going to
9 cut you off, sorry, since the time has been
10 up for a while. Thank you.
11 We've been joined by Senator Biaggi,
12 and our next questioner is Senator Brad
13 Hoylman.
14 SENATOR HOYLMAN: Good to see you,
15 Doctor -- Commissioner. I never know what to
16 call you, Doctor or Commissioner. How about
17 Dr. Commissioner?
18 I wanted to ask two general sets of
19 questions. The first is about your work on
20 vaping and flavors; I appreciate that. As
21 you know, the FDA came out with a directive
22 that I would imagine you would agree is
23 insufficient because it has nothing about
24 open-tank system or disposable vape products,

1 many of which are flavors. I'm looking at a
2 list of them here, flavors like Cherry Crush,
3 Pomegranate, Watermelon Ice -- all of those
4 flavors that some of the vaping companies
5 like JUUL have voluntarily stopped selling.
6 Are you seeing an increase in
7 disposable vaping products? I've heard this
8 from my constituent parents who have children
9 who are middle schoolers and high schoolers,
10 and they've switched from products like JUUL
11 to products like VGOD, blu, MOJO, NJOY, XPod,
12 Posh, Element that, one, use disposables.
13 COMMISSIONER ZUCKER: I have to find
14 out the answer to that question. I've heard
15 that people are using these disposables, but
16 whether an increase or not, I'll find out.
17 I'm not sure.
18 SENATOR HOYLMAN: Secondly on that
19 issue, what would you tell my colleagues who
20 I think are rightly concerned that if we do
21 pass legislation to ban flavored e-cigarette
22 products, that it might increase black market
23 use? In fact, that's what Donald Trump said,
24 no less an authority than Donald Trump.

1 COMMISSIONER ZUCKER: So I think that
2 the challenge here is that we have recognized
3 in the past the amount of the dangers of
4 having kids get addicted, and I think we need
5 to make all efforts to prevent that from
6 happening. We need to tackle this as -- the
7 way we're doing, the Governor's budget
8 proposals, with all the different issues we
9 mentioned: Banning the flavored nicotine
10 products and prohibiting the sale of tobacco
11 products, including e-cigarettes, to all
12 youth, and the advertising issues, to get rid
13 of these advertising of vaping-related
14 products, and many other things that we're
15 tackling here on this, whether it's banning
16 certain carrier oils, all of that.
17 I think in response to your specific
18 question whether this will go underground, I
19 can't say a hundred percent for sure. But we
20 will work to prevent that from happening as
21 well. I think -- I have a lot of faith in
22 our youth that if we educate them, if we
23 provide them with information, that they will
24 recognize the dangers that could befall them

1 if they start to use products that are unsafe
2 for them. And I think that if we explain
3 that if you get this product from the black
4 market or something of that nature, it's
5 still dangerous to you and you can get pretty
6 seriously injured.
7 SENATOR HOYLMAN: Well, thank you.
8 And I hope we can address this even before,
9 you know, the budget is completed, because as
10 you know, there were two deaths recently.
11 And every day, I think, with these products
12 on the market is dangerous --
13 COMMISSIONER ZUCKER: I agree.
14 SENATOR HOYLMAN: -- for New Yorkers
15 and especially children, as you have pointed
16 out repeatedly, which again I appreciate.
17 Very quickly on a local issue, there
18 is a senior residence in my district that I
19 share with Assemblywoman Rosenthal called
20 Riverview Independent Senior Living. They
21 announced recently, with no warning to
22 tenants, that they'd be selling the building
23 and closing the facility within months. That
24 left many of the elderly tenants, including a

1 99-year-old Holocaust survivor, worrying
2 about where they would live next.
3 They don't appear in DOH's registry of
4 licensed assisted-living services because
5 they skirt the regulations. But they offer
6 this wide array of services to seniors that
7 would seem to place them within the
8 department's purview, such as meals,
9 housekeeping, laundry services, emergency
10 alert buttons, 24-hour security, maintenance,
11 transportation, visiting medical
12 professionals.
13 Do you think that their operating
14 model, that Riverview's operating model is
15 one that should require examination for
16 licensure or regulation by the Department of
17 Health?
18 COMMISSIONER ZUCKER: Let me see if I
19 understand your question. You're asking
20 whether we feel that the models that we have
21 in place address the needs of seniors in some
22 of these long-term care or facilities is the
23 right model that we have? Is that --
24 SENATOR HOYLMAN: Exactly. In other

1 words, this independent living facility
2 provides services to seniors, but they're not
3 regulated by the Department of Health.
4 COMMISSIONER ZUCKER: So that's a
5 great question. I think this is where the
6 whole issue of the aging population in the
7 state and how we provide services to them
8 needs to continually be addressed and
9 modified accordingly, because as I mentioned
10 before, the population of those who are
11 seniors in the state is increasing, and the
12 support they need increases as well,
13 particularly when you're talking 99, 95 --
14 it's a lot different than 75. And so I think
15 we just have to adjust.
16 And the Governor, as I said, is
17 committed to the issues of the aging. I know
18 our team in the department have been working
19 on this with both the long-term-care
20 facilities, home care. I've had them in my
21 office multiple times looking at what else we
22 could do to provide care for those who are
23 caregivers, how we can remove some of the
24 issues of some of the challenges including

1 depression among those who are lonely. We're
2 working with the Office of Mental Health on
3 that issue.
4 And so all these issues come into
5 play, and I think that, you know, what's our
6 role in regulating this or what's our role in
7 addressing it, I think that we need to take
8 another look at it and see what we can do. I
9 don't want to add, you know, another
10 challenge for those in the community or
11 regulate another area, but whatever is best
12 for those who are elderly, we will do as a
13 state.
14 SENATOR HOYLMAN: Thank you very much.
15 CHAIRWOMAN KRUEGER: Thank you.
16 Assembly.
17 CHAIRWOMAN WEINSTEIN: We've been
18 joined by Assemblyman Blake, Assemblywoman
19 Gunther. And we go to Assemblyman Garbarino
20 for questions.
21 ASSEMBLYMAN GARBARINO: Thank you.
22 Director, Commissioner, nice to see
23 you.
24 I just want to get back to the MRT

1 real quick. I know you confirmed before that
2 the Legislature is going to have
3 appointments. I know this has at least been
4 eight days since the Governor announced that
5 it was going to happen. So I know you don't
6 know who the people are yet, but I would
7 expect that you would know what agencies or
8 what groups would have spots. Can you
9 confirm whether or not the health plans will
10 have somebody on? The health plans, anybody
11 from them?
12 COMMISSIONER ZUCKER: I don't have the
13 answers on all of that yet, but we'll be
14 happy to get back to you about which aspects
15 of the Legislature, the stakeholders and all
16 of that. But we will get that to you as soon
17 as we can.
18 ASSEMBLYMAN GARBARINO: I know you
19 don't know the people, you don't even know
20 who's -- what -- what agencies you're looking
21 at or what departments or --
22 COMMISSIONER ZUCKER: Not yet. And I
23 know you're saying it's been eight days, but
24 the fact is that everyone's been working on

1 this, and I will -- I'll get back to you on
2 that.
3 ASSEMBLYMAN GARBARINO: I want to go
4 back to -- also in the State of the State the
5 Governor said that -- no new taxes. But the
6 budget director did not rule out taxes on
7 health plans -- on health plans, I believe,
8 in a press conference.
9 So it's a little confusing. Are new
10 taxes off the table or on the table?
11 COMMISSIONER ZUCKER: I guess that's a
12 question back for the budget team, and I'll
13 have to ask, you know, Mr. Mujica on some of
14 the questions that were raised.
15 But if the Governor said no new taxes,
16 then there's no new taxes.
17 ASSEMBLYMAN GARBARINO: Okay. We just
18 had recent -- in December -- 1 percent cuts
19 on Medicaid rates, I believe, went into
20 effect. Administrative cuts, Medicaid,
21 1 percent in December. Has Deloitte
22 certified that those new rates are
23 actuarially sound?
24 MEDICAID DIRECTOR FRESCATORE: Yeah,

1 the -- I think you're referring to there's
2 appropriation authority in the enacted
3 budget --
4 ASSEMBLYMAN GARBARINO: Yup.
5 MEDICAID DIRECTOR FRESCATORE: -- to
6 allow for up to $190 million in across-the-
7 board cuts.
8 The total for this fiscal year in
9 across the board was 62 million. So, you
10 know, far shy -- we were able to figure that
11 out, so far shy of 190 million. Of that, the
12 healthcare plans, because they're about a
13 $48 billion spend, actually are allocated
14 about 41 of the 62.
15 As always, when we change premium
16 rates, we are required under federal rules to
17 have independent actuaries certify the
18 actuarial soundness of the rate. And that
19 was in fact done by Deloitte, because they
20 are our contracted actuary.
21 ASSEMBLYMAN GARBARINO: Is there a
22 report or --
23 MEDICAID DIRECTOR FRESCATORE: They
24 don't typically issue a report for each of

1 the actions. As you might know, these
2 premium rates can change many times during
3 the year, often the result of enactment of
4 legislative program changes or legislative
5 directives.
6 ASSEMBLYMAN GARBARINO: Aren't they
7 required to share their findings with the
8 health plans, under law?
9 MEDICAID DIRECTOR FRESCATORE: We are
10 required to -- they are required to make a
11 certification. We can look and see how
12 detailed that report is. But we would not
13 advance rates -- you know, as you may know,
14 there's an actuarial soundness range in which
15 the rates must fall, and that's the
16 certification, is that a premium rate would
17 fall within that acceptable range, which
18 is --
19 ASSEMBLYMAN GARBARINO: But the new
20 rates, the 1 percent, they've been --
21 MEDICAID DIRECTOR FRESCATORE: Pardon
22 me?
23 ASSEMBLYMAN GARBARINO: Have they been
24 certified, the new rates, after the 1 percent

1 cut?
2 MEDICAID DIRECTOR FRESCATORE: Yes.
3 ASSEMBLYMAN GARBARINO: Okay. You
4 mentioned before about going after assets as
5 a tool that the counties could do with --
6 under the state -- under the 3 percent for
7 Medicaid growth. Are you suggesting counties
8 should possibly file liens on people's
9 properties or go after spousal refusal or
10 something like that?
11 MEDICAID DIRECTOR FRESCATORE: Yeah,
12 Assemblyman, just for clarification, I think
13 I was asked whether or not that was the
14 suggestion, to go after assets. And the
15 answer to that was no, that's not
16 specifically -- I should, you know, probably
17 say that we believe that the local
18 districts -- and again, we intend this to be
19 a partnership. The local districts are on
20 the ground, they know their districts really
21 well. And they know their Medicaid program
22 locally. And it's been a partnership of
23 developing initiatives in partnership with
24 them, not dictating a list from the

1 Department of Health to the local districts.
2 What I was mentioning is that over
3 time, and you might remember some years ago
4 there were local demonstration projects, they
5 go probably back many, many years. And some
6 districts have found, for example, that they
7 can -- they use databases, data sources when
8 someone is applying that they review or look
9 at to be able to test to see if there are
10 other resources that are available that would
11 factor into the initial eligibility
12 determination.
13 ASSEMBLYMAN GARBARINO: Like spousal
14 refusal, but right now a spouse can refuse
15 the support --
16 MEDICAID DIRECTOR FRESCATORE: Well,
17 that we all -- we all -- not necessarily
18 spousal refusal. I mean, we would expect the
19 districts, just as when we make our
20 determinations, would follow whatever the
21 existing federal and state law is.
22 ASSEMBLYMAN GARBARINO: Okay. Just
23 one last question, and going back to tobacco.
24 There's something that prohibits the display

1 of tobacco products and vaping in stores. We
2 couldn't find it, I don't think, in the
3 language. Is there an exemption for actual
4 tobacco stores or vaping stores that are
5 specifically, you know, just for that?
6 COMMISSIONER ZUCKER: I'm not sure
7 about that. I'll have to get back to you
8 with any exception.
9 ASSEMBLYMAN GARBARINO: Should there
10 be? I mean, you don't want to walk into a
11 store with empty shelves.
12 COMMISSIONER ZUCKER: Well, tobacco --
13 I mean, the rule is that if it's a vaping
14 store, then they could sell product. We
15 don't want flavored product sold. But I'm
16 not going to -- I don't want tobacco sold
17 in --
18 ASSEMBLYMAN GARBARINO: I understand
19 that.
20 CHAIRWOMAN WEINSTEIN: Thank you.
21 To the Senate.
22 CHAIRWOMAN KRUEGER: Thank you.
23 Senator Gallivan, the ranking member on
24 Health.

1 SENATOR GALLIVAN: Thank you, Madam
2 Chair.
3 Can you tell me, how much does the
4 state spend on Medicaid?
5 MEDICAID DIRECTOR FRESCATORE: I'm
6 sorry, how much does the state spend on
7 Medicaid? The global -- the global cap
8 number for this year is -- let me get that
9 for you exactly -- 23.6 billion --
10 CHAIRWOMAN WEINSTEIN: Can you put the
11 mic a little closer to you?
12 MEDICAID DIRECTOR FRESCATORE: Yeah, I
13 don't want to rustle papers here and be
14 distracted. Let me get you that exact
15 number, which is the global cap calculation
16 from the State Financial Plan.
17 It is, for this current year, for
18 2020, the state calculation is 22.3 billion,
19 that's state share spending. And for 2021,
20 the projected spending under the global cap
21 is 23.6 billion.
22 SENATOR GALLIVAN: This upcoming year,
23 what is that number again?
24 MEDICAID DIRECTOR FRESCATORE:

1 Twenty-three-point-six billion.
2 SENATOR GALLIVAN: So that's global
3 cap, right?
4 MEDICAID DIRECTOR FRESCATORE: That's
5 the state spending, DOH state spending,
6 that's right.
7 SENATOR GALLIVAN: Okay. What other
8 Medicaid spending is there? There's Medicaid
9 spending that's exempted from the cap.
10 MEDICAID DIRECTOR FRESCATORE: There
11 are some -- there is some spending, I don't
12 have that detail here, we can get that for
13 you, that would not be under the global cap
14 under the way the cap is currently
15 structured.
16 SENATOR GALLIVAN: You don't know
17 that?
18 MEDICAID DIRECTOR FRESCATORE: I don't
19 have those exact numbers.
20 SENATOR GALLIVAN: I'm thinking it's
21 around 6 billion, but I don't know for sure.
22 MEDICAID DIRECTOR FRESCATORE: Yeah, I
23 don't have those exact numbers with me, and I
24 don't want to misspeak there. I want to make

1 sure you have the correct information.
2 SENATOR GALLIVAN: Let's go back to
3 the global cap. And I'm looking at the last
4 report that just came out, the April through
5 December 2019 report. And I've got close to
6 $193 million, I think it is, that's actually
7 non-Medicaid spending that's funded by the
8 Medicaid global cap -- non-Medicaid programs.
9 So some supportive housing, Alzheimer's
10 caregiver support, among other things.
11 I don't need to get in all the exact
12 dollars, I just -- but you know what I'm
13 talking about?
14 MEDICAID DIRECTOR FRESCATORE: There
15 are some -- there's --
16 SENATOR GALLIVAN: Non-Medicaid
17 programs funded out of the Medicaid global
18 cap, where we are not getting federal dollars
19 for it.
20 MEDICAID DIRECTOR FRESCATORE: Yeah, I
21 mean there's a number of -- there's spending
22 that's state-only for a variety of reasons.
23 There are some programs that have a Medicaid
24 allocation that currently counts against the

1 Medicaid spending cap.
2 SENATOR GALLIVAN: So my question
3 would be, though, given this deficit that we
4 have, this seeming elusive number, wherever
5 the actual number is, the point remains the
6 same. Why would we include non-federal
7 Medicaid spending under the Medicaid global
8 cap when we can't get reimbursement for it?
9 Wouldn't that be better placed under the
10 general operating budget and then you could
11 shift things that we could get reimbursed,
12 there could be a federal match for under the
13 global cap?
14 MEDICAID DIRECTOR FRESCATORE: Well, I
15 think it would be helpful -- I mean, we can
16 certainly, you know, talk about specifics and
17 talk along with the Division of the Budget,
18 but there are a number -- there's different
19 spending categories under the global cap that
20 do not have a federal share. And we can
21 certainly talk about the ones that you're --
22 that, you know, you might have specific
23 questions about.
24 SENATOR GALLIVAN: Okay. There's more

1 discussion to follow, but for the sake of
2 time, if we could move on. Statewide
3 Healthcare Facility Transformation Program
4 capital. In fiscal year '19 we allocated an
5 additional $425 million for our hospitals and
6 their various needs. And there hasn't been
7 any requests for application that's sent out
8 yet; I'm wondering when that's going to take
9 place.
10 COMMISSIONER ZUCKER: We'll check on
11 that. For the capital -- the most -- the
12 next round of capital for hospitals?
13 SENATOR GALLIVAN: Yes.
14 COMMISSIONER ZUCKER: So that's No. 3
15 that we're talking about.
16 SENATOR GALLIVAN: It is No. 3, yes.
17 COMMISSIONER ZUCKER: Yes, and I will
18 get you the information as to when. We put
19 out a lot of resources, obviously, to -- on
20 the previous capital grants to the hospitals,
21 and they have been helpful and successful to
22 improve hospitals across the state.
23 SENATOR GALLIVAN: Very helpful and
24 successful for the hospitals. But as you

1 know, it's tough to run a hospital whether
2 it's in the City of -- the biggest one in the
3 City of New York or the smallest, most rural
4 one.
5 COMMISSIONER ZUCKER: I agree. And --
6 SENATOR GALLIVAN: And we work hard to
7 put -- we work hard to come up with the money
8 to put in place for a program, and now they
9 just sit there and they're waiting and
10 waiting and waiting, and we promise. And
11 we're waiting on you.
12 COMMISSIONER ZUCKER: I know we've
13 given out the capital that has been provided
14 to the hospitals. All of those have been --
15 the last rounds --
16 SENATOR GALLIVAN: The last rounds, I
17 know.
18 COMMISSIONER ZUCKER: -- right, have
19 been provided to those facilities. And we
20 will go to the third round as well. And I'll
21 get you the --
22 SENATOR GALLIVAN: Could you please
23 let us know?
24 COMMISSIONER ZUCKER: I'll get you the

1 data on that as well.
2 SENATOR GALLIVAN: Thank you.
3 COMMISSIONER ZUCKER: Sure.
4 CHAIRWOMAN WEINSTEIN: We go to
5 Assemblyman Sayegh.
6 ASSEMBLYMAN SAYEGH: Thank you very
7 much, Commissioner Zucker, Director
8 Frescatore. A couple of quick questions.
9 Over the last number of years -- and
10 this is really a general question involved in
11 primary care solo medical practices. The
12 trend the last 20 years -- not only in New
13 York, across the country -- has been to
14 really consolidate medical practices.
15 Therefore, many patients are concerned that,
16 similar to losing the mom-and-pop stores, the
17 old days where you had your local businesses
18 and the constituents or the customers or the
19 patients, in this case, really had a
20 one-to-one close relationship with medical
21 doctors. They feel that they're losing that
22 and that there isn't really enough effort to
23 really allow solo practitioners to really
24 even think about opening practices like in

1 the past. And many are being forced to join
2 groups or other arrangements, and patients
3 have lost that valuable service of knowing
4 their medical doctor and being able to go and
5 get treatment from that medical doctor.
6 And the second question, you know, we
7 recently last year passed bold vaccination
8 policy and procedures. We limited medical
9 exemptions to some extent. Medical doctors
10 for those children that are not attending
11 schools, that really feel there's a
12 legitimate concern for their health and
13 safety, in some cases may be qualified and
14 allowed to take or get medical exemptions.
15 What can we do to really keep that
16 practice alive? Whereas we got rid of
17 religious exemptions -- I'm not sure what the
18 number is, but they stated as high as 26,000
19 kids out of schools. So what can we do to at
20 least protect those children with medical
21 exemptions and make sure that the medical
22 profession doesn't look at it as a stigma?
23 COMMISSIONER ZUCKER: Sure. Thank
24 you. And thank you for those questions.

1 Let me start with the first one
2 regarding primary care. So I wear two hats
3 on this one; I wear the hat in the role as
4 commissioner; I wear the hat as a doctor.
5 And I will tell you that I have my primary
6 care doctor, I like my solo practice primary
7 care doctor, and I like sitting down and
8 having a chance to speak with him about many
9 different issues. And I feel for the
10 physicians who are in solo practice feeling
11 that -- as this whole change in how medicine
12 is being practiced.
13 Part of it is that there are changes
14 in the way healthcare is going. Part of it
15 is that the asks that are being placed upon
16 physicians is quite enormous, and in order to
17 actually be able to continue to practice and
18 balance all the competing interests, both
19 professional and personal, it ends up that
20 there are groups, and then ultimately what
21 happens, sometimes hospitals bring those
22 groups into their fold.
23 This is something which -- the role of
24 the physician is something which I have been

1 thinking about a lot and in fact will be
2 bringing together and working on this right
3 now, a meeting with all of the different
4 groups and physicians to address the future
5 of the physician-patient relationship, the
6 relationship between the physician and access
7 to care and physicians in hospitals and
8 technology.
9 So I hope I will be able to, either
10 prior to the next time we are in a hearing
11 like this, or separately in a meeting with
12 you, to share some of what comes out of that
13 discussion which will be coming in the
14 spring.
15 That's one part, and I recognize that.
16 With regards to the second question on
17 immunizations and the exemptions, we have had
18 unprecedented success with preventing measles
19 from spreading, not just in New York but in
20 the nation. The -- it's really the school
21 districts. When it comes to medical
22 exemptions, if someone has a medical
23 exemption, then we recognize that and respect
24 that. But it is within the school system.

1 It's not the Department of Health that issues
2 that, so it's within the school system.
3 We're happy to work with the school
4 systems on that, but that's where it has to
5 go, between the health professional --
6 doctor, nurse, practitioner -- to the school
7 on that.
8 But I will say that there's been a lot
9 of work on these issues, and I just feel that
10 the benefits of immunizations and what we can
11 do is one of the great public health
12 achievements. But I do recognize the
13 challenges of particular cases, specific
14 cases where there is truly a medical
15 exemption.
16 ASSEMBLYMAN SAYEGH: Thank you very
17 much.
18 CHAIRWOMAN WEINSTEIN: Thank you.
19 We go to Senator Myrie.
20 SENATOR MYRIE: Thank you both for
21 your testimony.
22 I represent Central Brooklyn that, as
23 you know, is in the throes of a black
24 maternal morbidity and mortality crisis.

1 There are a number of social determinants
2 that contribute to that as well, and I think
3 it is in part the reason why the Governor a
4 few years ago rolled out, to much fanfare,
5 the One Brooklyn Health System.
6 My questions are going to be around
7 the ICP and how it relates to that system
8 insofar as us being ground zero for many of
9 the contributors to the mortality crisis, and
10 the impact that the distribution of ICP funds
11 will have on the One Brooklyn Health System.
12 So it is my understanding that One
13 Brooklyn Health has already, by way of the
14 cuts in January, had a $3.8 million cut due
15 to the 1 percent Medicaid reduction. It is
16 my understanding that they are also absorbing
17 the costs for the 1199 contract, to the tune
18 of 16 to 18 million dollars. And the
19 distribution formula as it currently stands
20 for ICP funds disadvantages hospitals and
21 systems like One Brooklyn Health that have a
22 disproportionate Medicaid consumer
23 population.
24 And so my question is, while there is

1 currently legislation by my colleague Senator
2 Rivera that would redirect ICP funds to
3 hospitals of the greatest need, I'm wondering
4 if there is action that the Health Department
5 could take right now in light of all of the
6 things that I just mentioned.
7 COMMISSIONER ZUCKER: So let me -- the
8 first part of this is that the One Brooklyn
9 Health is one part of the bigger initiative
10 Vital Brooklyn, which is the Governor's
11 initiative to look at all the social
12 determinants of health. And One Brooklyn
13 Health is something we have moved forward,
14 and I believe will actually, as I've said
15 before in this room, be a model for
16 healthcare reform for all urban areas across
17 the country. So we're moving that forward.
18 On the specifics of the Medicaid and
19 the $3 billion cut -- Donna, do you know
20 about that amount?
21 MEDICAID DIRECTOR FRESCATORE: Yeah, I
22 don't know -- I don't know -- have it
23 provider specific. But it could offer those
24 certainly, Senator. There's been a few

1 different actions that impact Medicaid
2 revenue to a particular facility, including
3 the trend, the 2 percent trend, the first
4 trend that had been done on the Medicaid
5 program I think since probably 2011. That
6 certainly has an upward impact. And then, as
7 you mentioned, the across-the-board --
8 CHAIRWOMAN WEINSTEIN: Excuse me,
9 Donna. We need you to really talk into the
10 mic, because it's not -- the acoustics are
11 just really not great in this room.
12 MEDICAID DIRECTOR FRESCATORE: You
13 can't hear up there? Okay. Sorry about
14 that. Apparently these don't come any
15 closer.
16 So there's a number of factors I think
17 that impact the Medicaid reimbursement to a
18 particular facility. We certainly can, you
19 know, talk offline about those in particular.
20 You mentioned the across-the-board,
21 which was pursuant to the appropriation
22 authority. In this budget you I think know
23 there was also a 2 percent across-the-board
24 increase, the first increase to hospitals I

1 think since 2011, so a very long time. And
2 how things work together, we're happy to sit
3 down and go over.
4 On the distribution, I think you all
5 know that we met many times with a workgroup
6 on the indigent care pools -- I should say
7 what ICP is -- to talk about the current
8 distribution formulas. We heard many, you
9 know, comments, concerns about how the
10 formulas currently work now, and we want to
11 continue to have that dialogue over the
12 course of the next weeks and months. We
13 understand how critically important that
14 funding is to the hospitals -- all hospitals,
15 but in particular those who serve a large
16 percentage of people who are Medicaid or
17 self-pay.
18 SENATOR MYRIE: I appreciate that and
19 would underscore how important that funding
20 is.
21 And I imagine that there's not going
22 to be a different answer here -- no matter
23 how artfully or creatively we ask about the
24 constitution and transparency of MRT II, I

1 don't believe we're going to get the answer
2 to that. But I will advocate for a
3 representative from our SUNY institutions and
4 also from our HHC institutions in the city.
5 I think it is critically important, with the
6 cuts that we are facing, particularly in
7 areas that I represent, and particularly on
8 the black maternal morbidity and mortality
9 crisis. I think it is critical that those
10 voices are elevated on any decisions that are
11 going to be made as it pertains to Medicaid
12 provision.
13 Thank you.
14 CHAIRWOMAN WEINSTEIN: Thank you.
15 We go now to Assemblyman Braunstein.
16 ASSEMBLYMAN BRAUNSTEIN: Good morning.
17 My question is about the cost shifts
18 to the localities and how it interacts with
19 the 2 percent property tax cap.
20 So how would it work if a locality
21 doesn't comply with the 2 percent tax cap?
22 They have to take up the entire increase in
23 Medicaid, not just over 3 percent?
24 COMMISSIONER ZUCKER: It would be the

1 difference, the -- if the -- well, if they
2 don't meet the 2 percent property tax, then
3 they would pick up the cost. If the
4 Medicaid -- if they go over the 3 percent
5 spending, then they would pick up the
6 difference on that. So if they're over
7 2 percent property tax.
8 ASSEMBLYMAN BRAUNSTEIN: So how would
9 it work for the City of New York, right? The
10 City of New York is not subject to the 2
11 percent property tax cap. It's likely that
12 they're not going to comply another year with
13 the 2 percent tax cap. So do they pick up
14 just more than 3 percent of their increase in
15 Medicaid spending, or do they pick up the
16 entire increase in Medicaid spending?
17 COMMISSIONER ZUCKER: Well, there's
18 two parts. One is the 2 percent, and if they
19 go over that, they pick up the cost. With
20 the Medicaid, if they go over the 3 percent,
21 then they pay the difference on the Medicaid.
22 But did you want to --
23 MEDICAID DIRECTOR FRESCATORE: Yeah,
24 yeah. I think that, you know, it's probably

1 important to preface this with, you know,
2 some of the history here, which was that the
3 intention of taking over the growth in
4 Medicaid, the state taking it over, was to
5 relieve localities so that they could --
6 ASSEMBLYMAN BRAUNSTEIN: I understand
7 the logic.
8 MEDICAID DIRECTOR FRESCATORE: -- they
9 could implement the 2 percent.
10 So the proposal really is two
11 measures, to answer your question. That if
12 the localities grow their property taxes by
13 more than 2 percent, they would be
14 responsible for the Medicaid growth. For
15 those localities that are within the property
16 tax cap, they would be responsible for growth
17 over 3 percent.
18 And then we had talked before about if
19 the growth in those counties is less than
20 3 percent, they would share in the savings.
21 ASSEMBLYMAN BRAUNSTEIN: Okay. So as
22 I said earlier, the City of New York has
23 never been subject to the 2 percent property
24 tax cap. Historically the property tax levy

1 has always exceeded 2 percent. It's -- I
2 think everybody understands that moving
3 forward, for the way the city budgets, that
4 it's probably not going to abide by the
5 2 percent cap.
6 2018-2019, Medicaid spending in the
7 City of New York increased by 7 percent. So
8 if we have another year of 7 percent, the
9 city is supposed to pick up the entire
10 7 percent?
11 MEDICAID DIRECTOR FRESCATORE: It
12 would be what the growth --
13 COMMISSIONER ZUCKER: The growth. It
14 would be growth.
15 MEDICAID DIRECTOR FRESCATORE: -- was
16 year over year.
17 ASSEMBLYMAN BRAUNSTEIN: Do you have
18 an estimate of how much that's going to cost?
19 MEDICAID DIRECTOR FRESCATORE: I don't
20 have -- I don't have -- I don't have --
21 ASSEMBLYMAN BRAUNSTEIN: Okay. Well,
22 the city --
23 MEDICAID DIRECTOR FRESCATORE: -- on
24 that. We know there are some --

1 ASSEMBLYMAN BRAUNSTEIN: The city has
2 an estimate. The city Office of Management
3 and Budget estimates that if it were to incur
4 a 7 percent increase this year, that's a cost
5 shift of $1.1 billion.
6 MEDICAID DIRECTOR FRESCATORE: We've
7 seen that. We saw that -- we've seen that
8 estimate. We did not compute that estimate.
9 I don't have, you know, a separate estimate
10 for you today.
11 ASSEMBLYMAN BRAUNSTEIN: Okay. Now,
12 should the city somehow magically comply with
13 the 2 percent tax cap, they would only incur
14 646 million. But, you know, I can't help but
15 think that the inclusion of New York City
16 with the 2 percent tax cap is nothing more
17 than a mechanism to shift the entire burden
18 of the Medicaid increase -- unfairly,
19 compared to other counties that comply with
20 the 2 percent cap -- to the City of New York.
21 And I'm very troubled by what they're
22 estimating is a $1.1 billion cost shift. And
23 considering the fact that the city has never
24 been subject to the 2 percent tax cap, I'm

1 urging you to reconsider that requirement in
2 this proposal. Thank you.
3 CHAIRWOMAN WEINSTEIN: We've been
4 joined by Assemblywoman Griffin.
5 Then we're going to the Senate.
6 CHAIRWOMAN KRUEGER: Thank you.
7 Senator Jen Metzger.
8 SENATOR METZGER: Thank you, Madam
9 Chair. And thank you, Commissioner.
10 I represent the 42nd District, which
11 includes all of Sullivan County, the western
12 part of Orange County, Ulster, and Delaware
13 Counties. Very rural areas.
14 I want to start off first by just
15 echoing some of the concerns that Senator
16 Seward brought up, and comments on the
17 importance of emergency management services
18 having a seat at the MRT II table. And I
19 would ask that you make sure that there is
20 some geographic balance in that
21 representation, because rural EMS is really
22 struggling.
23 Secondly, I wanted to speak to the
24 proposed rural healthcare program

1 consolidation. I'm extremely concerned about
2 that.
3 Our rural communities across the state
4 are grappling with accessibility issues. In
5 Sullivan County, the county ranks second from
6 the bottom in health outcomes. So these are
7 serious issues. This is actually a county
8 that both my neighbor right here,
9 Assemblywoman Gunther and I, both represent.
10 Both Sullivan and Ulster Counties are in the
11 highest quartile for opioid deaths in the
12 state.
13 So I want to know, where is this
14 $3.72 million in savings coming from? How is
15 it going to impact the delivery -- the
16 success of these programs to date, which are
17 so important?
18 COMMISSIONER ZUCKER: So I'm unclear a
19 little bit about your question. I mean, I
20 recognize the challenge in Sullivan County
21 very well. As a matter of fact, my family
22 has a home in Sullivan County, so I've
23 spent -- I've been there, spent time there.
24 Are you referring specifically to

1 the --
2 SENATOR METZGER: I'm referring to the
3 consolidation of the Rural Healthcare Access
4 Development Program and the Rural Healthcare
5 Network.
6 COMMISSIONER ZUCKER: Right, so I
7 understand what you're saying. So we -- I
8 will have to get back on the details of how
9 we will find that.
10 But I will tell you, as I mentioned
11 before, that the rural health issues are
12 forefront on our agenda of trying to tackle,
13 whether it's the issues of Sullivan County or
14 any of the other counties in New York State
15 that the -- a lot of burdens have been placed
16 upon them, or the people who live there, as
17 less -- the access to some care is not as
18 robust as elsewhere.
19 So I recognize that. And we will
20 figure -- I can get back to you about the
21 details of where the money is going to come
22 from.
23 SENATOR METZGER: Okay, I would love
24 to get those details. Perhaps we can get

1 them in a break.
2 COMMISSIONER ZUCKER: We will do that,
3 I promise you.
4 SENATOR METZGER: Okay. And my
5 colleague would also like them.
6 COMMISSIONER ZUCKER: Fine. Not a
7 problem.
8 SENATOR METZGER: And then lastly I
9 just want to turn to the proposed regulation
10 of pharmacy benefit managers. This is a
11 program that started with great intentions
12 but, you know, it's ended up costing
13 consumers and really squeezing the
14 independent -- we love our small independent
15 pharmacies in our rural communities, and it's
16 been a huge problem for them.
17 I want to know why, if you could just
18 explain why the proposals do not include a
19 prohibition on spread pricing, which has
20 been --
21 COMMISSIONER ZUCKER: I didn't catch
22 the second part.
23 SENATOR METZGER: A prohibition on
24 spread pricing.

1 MEDICAID DIRECTOR FRESCATORE: I
2 would -- Senator, if you'd defer that,
3 actually, to our colleagues at the Department
4 of Financial Services.
5 I think you all know that for the
6 Medicaid program there was a prohibition on
7 spread pricing in this year's budget. We
8 require health plans and PBMs to --
9 CHAIRWOMAN WEINSTEIN: Would you --
10 it's hard to hear.
11 MEDICAID DIRECTOR FRESCATORE: I
12 apologize. We required health plans -- is
13 this better?
14 We required health plans and PBMs to
15 present to us contracts that eliminated
16 spread pricing, which they did, that went
17 into effect on October 1st for Medicaid.
18 It's too soon to know the dollar impact, but
19 it was -- every plan had to renegotiate its
20 contract.
21 But I would defer on the current
22 Article 7 to the Department of Financial
23 Services.
24 SENATOR METZGER: Okay, thank you.

1 CHAIRWOMAN WEINSTEIN: We go now to
2 Assemblyman Jacobson.
3 ASSEMBLYMAN JACOBSON: Thank you,
4 Madam Chair.
5 Dr. Zucker, I seem to be -- because of
6 the importance of your agency, I seem to be
7 writing letters to you every six weeks. I
8 want to start out with a compliment. I
9 thought that the ads you did on television
10 concerning the vaccination crisis were quite
11 excellent.
12 The reason I write to you all the time
13 is I'm from the City of Newburgh, and we have
14 the PFOS problem. And I was happy, though it
15 took a while, you've instituted the new
16 levels on PFAS/PFOS from the State Water
17 Quality Task Force, which was long overdue.
18 And there was recently money awarded
19 from the federal government to participate in
20 a multistate testing concerning these
21 chemicals.
22 And the reason, by the way, for those
23 that don't know, the reason that the City of
24 Newburgh's water supply has been

1 contaminated, that we cannot use it, is
2 because it was contaminated by the
3 firefighting foam used at Stewart Airport.
4 And because of that, we don't use it, we're
5 hooked up to the Catskill Aqueduct. And of
6 course my position has been that we should
7 continue to be hooked up to that, because I
8 don't think there will ever be appropriate
9 remediation.
10 But concerning the testing, I wrote to
11 you last month and I just received a letter
12 back from Dr. Ginsberg. I had requested that
13 when the testing was done, there would be
14 new -- that they retest people that had been
15 tested before so that we see if there's been
16 improvements and whether it has dissipated as
17 supposedly it's supposed to.
18 Dr. Ginsberg wrote back and said that
19 you were going to start new testing, which
20 would include people that had previously been
21 tested and those that haven't been. So
22 that's good to hear, and I'm very happy on
23 that.
24 The problem we've had previously in

1 the testing is there's not really been a
2 broad participation as much as there should
3 be. People are nervous, they don't like
4 getting their blood taken, all these things.
5 And I was hoping that you could work
6 something out -- and I understand privacy
7 rules, and I understand you have to get
8 consent -- but to work something out with
9 emergency rooms that too many people use as
10 their family doctor in Newburgh, and also at
11 the schools.
12 COMMISSIONER ZUCKER: I agree, I think
13 that this is a collaborative effort between
14 county and state on this. And I recognize
15 we've spent a lot of time on drinking water
16 and whether it's PFOA and PFOS or
17 1,4-dioxane. And I have learned that there
18 is sometimes some people don't want to be
19 tested --
20 ASSEMBLYMAN JACOBSON: But you could
21 do that.
22 COMMISSIONER ZUCKER: -- but we can
23 work with you and work with the community to
24 figure out what's the best way to get the

1 message out to everyone in the community
2 about testing and about what's the -- what
3 information it provides and what they could
4 learn from their result and when to be
5 retested in the future.
6 ASSEMBLYMAN JACOBSON: Well, one way
7 that you would get more people to participate
8 and less cynicism is that we need answers.
9 I mean, I had my blood tested. So you
10 got three different tests back. One said it
11 was median, one said it was above the median,
12 one said a little below. So I asked, "What
13 does this mean?" And every time I went to
14 the six or seven public hearings, the answer
15 was "We don't know."
16 COMMISSIONER ZUCKER: So that's part
17 of the challenges a little bit on the biology
18 aspect of this. We do know some information,
19 but we're learning more and more every day.
20 And ATSDR, which is the CDC branch, the
21 branch of the CDC that looks at some of these
22 issues on environment, they too have been
23 involved in looking at this on a national
24 level as to what does the result of X amount

1 mean.

2 We do know what the Governor asked us

3 to do is to push forward on addressing

4 drinking water quality, and we have the

5 most -- the most restrictive levels in the

6 nation. We've pushed the PFOA and PFOS down

7 to 10 parts per trillion. We've pushed

8 1,4-dioxane down to one part per billion.

9 We're moving forward on these issues. And we

10 do know from some of the other tests in other

11 parts of the state that the levels have

12 dropped when we've done follow-up testing.

13 So we will move forward. I think what

14 the answer to your question is is more

15 education, more information to the public,

16 and being able to share any view that we do

17 know. But the one thing -- sometimes we

18 don't have all the answers. And we will find

19 that out as we go.

20 ASSEMBLYMAN JACOBSON: Well, I

21 appreciate it. The only thing I was told,

22 there was a likelihood I would die between 60

23 and 90 years.

24 (Laughter.)

1 ASSEMBLYMAN JACOBSON: But they didn't
2 say it was from the PFOS. So we need more
3 information.
4 COMMISSIONER ZUCKER: We'll get that
5 for you.
6 ASSEMBLYMAN JACOBSON: All right,
7 thank you.
8 CHAIRWOMAN WEINSTEIN: Thank you.
9 Senate?
10 CHAIRWOMAN KRUEGER: Thank you.
11 Our next testifier is Senator May, who
12 I don't see. So we'll come back to her.
13 Our next testifier is Senator Diane
14 Savino.
15 SENATOR SAVINO: Good morning,
16 Commissioner.
17 So we had an opportunity to speak
18 earlier this week about medical marijuana, so
19 I won't bore the audience with the content of
20 the discussion.
21 I would like, though, to echo the
22 concerns of several of my colleagues about
23 the makeup of the MRT. I think it's
24 critically important that EMS be on it. As

1 you see, there's so many of them here behind
2 us.
3 Also, the New York City HHC. The last
4 MRT they really did not have a role. And
5 since they are the largest provider of
6 Medicaid services in New York City -- they
7 had a representative from the City of
8 New York, but not the HHC itself. So we
9 would hope that that would be part of it.
10 But I want to -- and also we spoke
11 about my concerns about vaping. I know for a
12 fact if we take -- if we ban the sale of
13 vaping products, people will go to the
14 illegal market. They do it now. And, more
15 importantly, they'll go back to smoking
16 cigarettes. So I think we should approach
17 this in a more deliberative way.
18 If we really want to get people to
19 stop using these products, we would demand
20 that they take the nicotine out of the
21 products. Because without nicotine, nobody
22 is going to smoke or vape. It has no
23 purpose.
24 But that being said, I want to talk

1 about you all have said numerous times today
2 the largest driving cost in the expansion of
3 Medicaid has been long-term care over the
4 past several years, and that's -- we all know
5 that that's true. And what's kind of curious
6 to me is with respect to the Medicaid
7 look-back period, for nursing homes it's five
8 years, but for long-term care it's only
9 30 days. And so do we think maybe it makes
10 more sense to extend the look-back period for
11 long-term care?
12 And then finally, if we know long-term
13 care is so extraordinarily expensive and
14 we're spending a disproportionate amount of
15 our Medicaid dollars on it, what can we do,
16 working with DFS, to encourage more people to
17 purchase long-term care? Because I hear from
18 many of my constituents who have invested in
19 a long-term care policy so that they don't
20 have to spend down their assets or give away
21 everything they have. But DFS has approved
22 premium increases and it's gotten to the
23 point where they can't afford the premiums
24 anymore. So we're kind of working at

1 cross-purposes.
2 What can we do to incentivize the
3 creation of long-term care products that are
4 sustainable for people so that they can have
5 some dignity and they don't have to give away
6 everything that they have and then rely on
7 Medicaid?
8 COMMISSIONER ZUCKER: I think that's a
9 good question. We should sit down with DFS
10 and have a conversation about that. And I
11 agree that people don't purchase it
12 because --
13 SENATOR SAVINO: It's expensive.
14 COMMISSIONER ZUCKER: It's expensive
15 and then the -- and it is a tough issue to
16 talk about, because -- not here, but when you
17 talk to relatives or others about long-term
18 care and the worry about, well, what if you
19 become incapacitated or there's a challenge,
20 what are you going to do? And sometimes
21 people shy away from that discussion and then
22 they discuss it when it's almost too late.
23 And so I agree, we should have that
24 conversation.

1 MEDICAID DIRECTOR FRESCATORE: Hi,
2 Senator. I would just add that I think that
3 the reconvening of the MRT gives us an
4 opportunity to talk in a more focused way
5 about long-term care than the first round,
6 and also exploring ideas like the one you
7 just, you know, discussed about different
8 options that make it possible for people to
9 contribute, you know, on a private-pay basis.
10 And we would concur that we would want to
11 work with DFS on the premiums and other
12 strategies for people to keep their, you
13 know, private money in the system as well.
14 SENATOR SAVINO: Several years ago we
15 adopted legislation that would allow people
16 to accelerate their death benefit on their
17 life insurance policies. Life insurance is
18 relatively inexpensive to purchase. And you
19 could, instead of leaving it to your
20 relatives, you could accelerate the death
21 benefit to pay for nursing home care. Maybe
22 we can explore expanding that to long-term
23 care as well.
24 Thank you.

1 CHAIRWOMAN KRUEGER: Thank you.
2 CHAIRWOMAN WEINSTEIN: Thank you.
3 Assemblywoman Gunther.
4 ASSEMBLYWOMAN GUNTHER: Good
5 afternoon.
6 My question has to do with the study
7 regarding safe staffing. We've been talking
8 about this issue year after year. We've put
9 off the issue for a long time, stating that
10 safe staffing, we had to do a study. And I
11 know as a physician you know that education
12 is important, and who gives education to
13 inpatients is the nurses.
14 Also we know that nurses are leaving
15 the profession earlier and earlier because,
16 number one, their license, and number two, we
17 get in that business not to be rich but to
18 provide good care.
19 We have put this off for a very, very
20 long time. I've had many administrators from
21 hospitals come and talk to me about it, about
22 the cost. But right now, with the nosocomial
23 infections and the rate of nosocomial
24 infections in our hospitals, that is causing

1 increased length of stay, also readmittance
2 to the hospital, and also bad care.
3 And as a nurse and as someone that has
4 been picketing for the last 13 years with no
5 answer, only pushback, pushback, you know,
6 we're waiting for something to happen. So
7 tell me the end of the study, tell me what it
8 told me, and tell me why that right now we're
9 not following Australia, another country, or
10 California to see that it didn't devastate
11 hospitals; rather, it provided better care.
12 COMMISSIONER ZUCKER: So I -- on the
13 report, we're finalizing that report. And as
14 you know and probably most people know, I
15 don't like to issue reports or put things out
16 until I have looked at everything to make
17 sure all the Is are dotted, all the Ts are
18 crossed. And so we're working on that. And
19 that will get done, and I assure you we will
20 get that to you.
21 I will echo your words of the role of
22 nurses, as I have worked with many nurses and
23 I know that we -- I couldn't do my job when I
24 was practicing without their assistance and

1 their professionalism and what they do in
2 taking care of patients at the bedside. So I
3 hear you. I hear you.
4 ASSEMBLYWOMAN GUNTHER: Dr. Zucker,
5 you know, I've heard that it will get done,
6 and it's been put off and put off. Like for
7 me, I pay my electric bill on the 15th of the
8 month. So there should be a date certain.
9 At least it would be an answer that we would
10 have a level of comfort. You know, the
11 nurses in Cornwall Hospital, in St. Luke's
12 Hospital, you know, we've been waiting a
13 very, very long time. And we are the
14 backbone of healthcare. We stay with our
15 patients. And if you look at the ratios on
16 the hospital I hear about, and the meds are
17 more complicated, people are living longer --
18 so this is like time to do it. They've done
19 it other places. We've put this off.
20 You know what? I'm probably going to
21 get killed for this one, but if you look at
22 what the salaries are of the administration
23 of hospitals -- and we talk about Medicaid
24 and the low reimbursement, that the

1 difference between the reimbursement -- you
2 know, if you go to a European country, it
3 don't look like that. It just doesn't. And
4 at this point we've waited long enough. We
5 are the backbone of hospitals and medicine.
6 We also mostly are women. And I repeat,
7 mostly women. We're angry women now, and
8 that's not a good thing.
9 (Laughter.)
10 COMMISSIONER ZUCKER: That's not a
11 good situation.
12 ASSEMBLYWOMAN GUNTHER: That's not a
13 good thing. I'm from the Bronx. You know,
14 we're kind of tough from the Bronx. But we
15 are women, and we want an answer and we want
16 it as soon as possible. A study -- you know
17 what, Doctor? You know that when you look at
18 something and you look at any trends, that it
19 doesn't a year long to actually say what is
20 happening here. It really doesn't. You know
21 that.
22 We used to do studies for years and
23 years, and they said to us: You know what?
24 That's ridiculous. When you see a trend,

1 it's telling you a story. The story is being
2 told, and it's been told by women over and
3 over again. And so I am requesting, asking
4 politely to please give us the answer that we
5 want. We need more staffing.
6 COMMISSIONER ZUCKER: I hear you.
7 CHAIRWOMAN WEINSTEIN: Senate.
8 CHAIRWOMAN KRUEGER: Just for the
9 audience, if you like something you hear, we
10 discourage clapping. This (gesturing) is
11 fine.
12 (Laughter.)
13 CHAIRWOMAN KRUEGER: Okay? This
14 (gesturing), not this. There you go. Thank
15 you.
16 Next up is Sue Serino.
17 SENATOR SERINO: Thank you, Madam
18 Chairwoman.
19 And I just want to echo my colleagues'
20 comments about our EMS and our nurses. As
21 somebody who just shattered her ankle this
22 winter, they were both so important to me.
23 So thank you for all of you being here today
24 as well. Greatly appreciated, thank you.

1 Dr. Zucker, so great to see you. I
2 can't count the amount of times that we've
3 talked about this subject, but Lyme disease.
4 So you know I'm always talking ticks.
5 (Laughter.)
6 SENATOR SERINO: But in last year's,
7 you know while the Senate did include a
8 million dollars in their one-house proposal,
9 ultimately it was left out of the final
10 budget. Towards the end of the session we
11 did put some funding in, but it was a real
12 significant cut that we just can't afford
13 from prior years.
14 Now, I know in the past you and I have
15 talked about bolstering public/private
16 partnerships when it comes to Wadsworth and
17 such. But the money that we add goes
18 directly to research and prevention
19 initiatives that we know are actually working
20 here in the state. You know, of all the
21 different places that we provide -- have
22 provided the funds for, it's very important.
23 So I have two questions, and I'll ask
24 them one at a time. What do we have to do to

1 ensure that the administration makes funding
2 to combat Lyme and tick-borne diseases a top
3 priority?
4 COMMISSIONER ZUCKER: So first, we are
5 working diligently on this issue. Between
6 DOH, DEC, we put out thousands of signs, I
7 think 8,000 signs, just notices about ticks,
8 particularly, obviously, during the season.
9 We are -- we have -- once again, when
10 tick season begins again, we will test
11 150,000 ticks again. We are working on the
12 issues of education to the public about this.
13 We are working and trying to get
14 public/private partnerships on this issue.
15 We recognize that the Lone Star tick and the
16 long-horned tick and all these different
17 specific ticks, whether it's out on Long
18 Island or elsewhere in the state, are of
19 concern.
20 We looked at all the issues of tick --
21 not just Lyme disease, but babesiosis,
22 ehrlichiosis, anaplasmosis, Powassan, all the
23 different other tick-borne diseases. And we
24 are working aggressively on this.

1 I was thinking about this issue the
2 other day because I was saying that, you
3 know, when I was a little kid I used to roam
4 around with my grandmother, picking
5 blueberries, and I didn't remember some of
6 these issues of getting -- that I wasn't
7 bitten by a tick. And so all these issues.
8 And there were deer there and everything in
9 the area. And I realized that this is
10 something which is growing, and it's growing
11 as the change in climate is growing, as the
12 many different changes that have taken place
13 in our environment.
14 And so we are aggressive on this.
15 Wadsworth, as you mentioned, our lab, is
16 working hard to address the public/private
17 partnership as well.
18 SENATOR SERINO: And I live in the
19 Hudson Valley, so of course we are the
20 epicenter. So -- and I appreciate all of the
21 work that you're doing with the
22 public/private partnerships. But I want to
23 ask you this question, because this is really
24 directly to what we need to do with these

1 specific locations.
2 Would you be supportive of putting at
3 least the million dollars to support the Lyme
4 and tick-borne disease research and
5 prevention initiatives in the 30-day budget
6 amendments?
7 COMMISSIONER ZUCKER: So let me get
8 back to you about that, because of this --
9 you know, about -- I've got to look at all
10 that. But I hear you. I hear what your
11 concerns are. I've got them here.
12 SENATOR SERINO: And then in the past
13 I've sponsored legislation that would require
14 the Healthcare Quality and Cost Containment
15 Commission -- so especially for my new
16 colleagues, Healthcare Quality and Cost
17 Containment Commission -- to consider
18 mandating insurance coverage for chronic
19 Lyme. As you know, the commission was
20 supposed to look at how much insurance
21 mandates would actually cost and the impact
22 that they would have on quality of care. So
23 that's actually something that makes a lot of
24 sense, right? Look at the cost, look at the

1 care. Whoever thought of that idea for the
2 cost containment commission, it was
3 brilliant. But the Assembly never appointed
4 its members to the commission, and as a
5 result, the Governor decommissioned it.
6 So given our current fiscal situation,
7 would the administration be supportive of
8 reinstating the Healthcare Quality and Cost
9 Containment Commission to ensure that all
10 lawmakers had access to this important
11 information when we're making these
12 decisions?
13 COMMISSIONER ZUCKER: We'll look at
14 that.
15 SENATOR SERINO: You'll look, okay.
16 Thank you.
17 And the last thing I wanted to ask
18 about was can you clarify whether or not
19 there's a cut being proposed to EPIC, a
20 program that many New Yorkers, seniors,
21 depend on to help pay for costly prescription
22 drugs?
23 COMMISSIONER ZUCKER: So we're looking
24 at the issue of -- just the overall issue of

1 the cost of prescription drugs, whether it's
2 for the elderly or for anyone, for that
3 matter. And trying to -- as the Governor has
4 said, that we need to figure out how to lower
5 the prices that are just -- some of them are
6 just exorbitant, whether it's medicines, for
7 insulin, as he raised, but also just in
8 general, and what else we can do. And
9 there's a whole team in the department trying
10 to address this as to how to lower costs.
11 MEDICAID DIRECTOR FRESCATORE: If I
12 could say specific to EPIC, Senator -- thank
13 you, Dr. Zucker -- there is a reestimate of
14 the cost of the program related to the
15 closing of the Medicare donut hole.
16 SENATOR SERINO: Okay. Because I
17 wanted to know, too, about the line in the
18 Executive Budget about the amendment.
19 Also, the financial plan says that the
20 EPIC program will be adjusted to reflect
21 declining program utilization, but I'm being
22 told that it is not being cut.
23 So it's kind of like we're going back
24 and forth on it. It's a little confusing.

1 And I know we still do a lot to try to
2 educate our seniors about --
3 MEDICAID DIRECTOR FRESCATORE: Yes.
4 SENATOR SERINO: -- that EPIC program.
5 MEDICAID DIRECTOR FRESCATORE: Yes.
6 SENATOR SERINO: So I'd hate to see it
7 cut.
8 MEDICAID DIRECTOR FRESCATORE: It's
9 certainly a very important program to
10 hundreds of thousands of elderly New Yorkers.
11 And I think that reference -- and
12 we'll get you a clarification on exactly what
13 it is -- is a reference to the donut hole
14 under Medicare Part D closing. And because
15 the EPIC program works as secondary payer to
16 Medicare Part D, that there's efficiencies in
17 the program that just result from Medicare
18 not having that hole anymore in coverage. It
19 was a multiyear phase to close that donut
20 hole. But we'll get you some clarification
21 on that.
22 SENATOR SERINO: Maybe we can talk
23 about it afterwards. It's such a great
24 program, and important.

1 Thank you.
2 CHAIRWOMAN KRUEGER: Thank you.
3 Assembly.
4 CHAIRWOMAN WEINSTEIN: We go to
5 Assemblywoman Miller.
6 ASSEMBLYWOMAN MILLER: Good morning.
7 So I have a few questions, I'll ask
8 them all at once. First, in light of this
9 overall deficit problem, it may seem crazy
10 for me to be asking about this, but as you
11 are very familiar, it's an issue that I've
12 been very concerned about. And if anything,
13 this budget challenge has only enhanced my
14 concerns.
15 How are we ever going to address the
16 emerging crisis of not having skilled care
17 providers in home care environments if we
18 don't find a way to pay the skilled care
19 providers a competitive wage? There are more
20 and more individuals with complex health
21 needs that are living longer and living in
22 their home care environments. But the lack
23 of a competitive increase in the RN/LPN rates
24 over the last many years has caused a

1 shortage of nurses to provide this care.
2 A nurse in the hospital, as you know,
3 makes about double what a nurse in home care
4 makes. And in the hospital, they have
5 benefits. Often in the home care environment
6 they're not offered benefits.
7 This crisis in itself is forcing
8 families to provide that skilled care, at a
9 cost. We've had to stop working or limit our
10 hours or work double time. In my case, I
11 work all day, often seven days, and then at
12 night I'm my son's nurse, I'm doing skilled
13 care. You have burnout.
14 And then on the other end of it, where
15 this has inadvertently increased the CDPAP
16 usage, because families are relying on other
17 family members. They'd much rather have
18 somebody that they know who cares about their
19 loved one provide that skilled care that they
20 can't get. And now that program is being
21 targeted because of that increase in its
22 usage. So how on earth are we going to
23 address this dire need?
24 My other question is the 1 percent

1 across-the-board tax cut for hospitals that
2 have other revenues, it hasn't really been so
3 devastating. But for these other community
4 groups and post-acute care groups, it has
5 been devastating. They're already
6 struggling. And if there are more increases,
7 how are they going to continue to provide
8 these services and the care that we need to
9 keep them in the community?
10 Does anybody -- I know you don't know
11 the makeup of the MRT, we've heard this over
12 and over. But can we beg you to make sure
13 that there are representatives that will be
14 looking out for this increased need in the
15 home care environment. You know,
16 Assemblywoman Gunther made that story -- you
17 know, you see a trend, it's telling a story.
18 Well, this story is just growing. And it's
19 indicative of a lot of people's lives across
20 this state.
21 COMMISSIONER ZUCKER: I hear you. I
22 hear you on the issue of the home care. We
23 have had multiple meetings about this, and
24 they continue. And I've brought in home care

1 agencies to discuss this exact issue about
2 how do you create an increase in professional
3 development so that if someone doesn't feel
4 it's just a job, that they can grow and
5 develop in the course of their career. How
6 do you give them more autonomy so that
7 there's a feeling that I am not restricted to
8 doing a certain number of things.
9 This is -- scope of practice issues,
10 this is something which we are -- it is
11 actually on the forefront of our issues in
12 the department. And I believe I actually
13 have a meeting with the home care agencies
14 again somewhere in the coming month to
15 discuss this.
16 And I hear you about this. And I do
17 hear you saying that it falls upon family
18 members to do this. And as one who had an
19 elderly dad, I recognize the amount of need
20 that home care provides. On the --
21 ASSEMBLYWOMAN MILLER: The home care
22 agencies will say that they can't do it
23 without money to pay a better wage.
24 COMMISSIONER ZUCKER: Right, I

1 understand. On the CDPAP, maybe Donna could
2 address that aspect of it as well.
3 MEDICAID DIRECTOR FRESCATORE: Yeah,
4 well, I would -- first of all, thank you for
5 the conversation that we've had over the past
6 many months on your concerns, particularly
7 about, I think, the availability of skilled
8 nursing in the home. And I think you've made
9 us, you know, certainly acutely aware of the
10 need and some of the reimbursement issues.
11 And, you know, we work case by case,
12 patient by patient to ensure that we're able
13 to put -- there's services in place. But we
14 would agree that we need a longer-term
15 strategy to address that. And so we're
16 hopeful that -- we hear about the MRT and the
17 representation, and that as that reconvenes,
18 that the importance of that part of care in
19 the home will be considered as well as the
20 other programs that are providing millions of
21 hours of care. So we appreciate that.
22 On the 1 percent across the board, if
23 there -- there are some providers who are
24 exempt from that and some -- so if you have

1 specific providers, maybe offline -- or types
2 of providers -- we can talk about how it
3 would impact them through implementation if
4 you would like.
5 ASSEMBLYWOMAN MILLER: Okay. And I
6 just think, in closing, that, you know, we
7 keep this trend of, you know, what's the
8 biggest drain? Long-term care. But it's the
9 thing that continuously gets cut. It's like
10 the first thing on the chopping block is --
11 but the trend is long-term care. Why do we
12 keep pushing it aside or pushing it to the
13 bottom?
14 CHAIRWOMAN KRUEGER: Thank you. I'm
15 going to cut you off now. Thank you.
16 Senator Alessandra Biaggi.
17 SENATOR BIAGGI: Thank you,
18 Madam Chair.
19 Donna, Commissioner, thank you very
20 much for being here.
21 Commissioner -- and I'm going to be
22 very cognizant of my time. In 2016 and 2018,
23 unprecedented language was added to the State
24 Budget at the very last minute authorizing

1 DOH to extend two specific contracts with
2 Maximus Inc. without being subject to the
3 state standard procurement laws. Since then,
4 your department has quietly and without
5 competition or OSC review and approval,
6 extended and expanded these two contracts so
7 that they are now collectively valued at
8 $3.6 billion, which is almost 12 times larger
9 than their original value.
10 One of these contracts is for the
11 New York State of Health Customer Service
12 Center, which was originally valued at
13 $170 million, but following three expansions
14 and extensions is now valued at 2.46 billion,
15 which is about 15 times larger than its
16 original award.
17 The second contract, for Medicaid
18 enrollment broker services, was originally
19 awarded for $140 million, and DOH has also
20 extended this project without competition or
21 OSC review. The most recent three-year
22 extension for this contract almost doubled
23 the value of this contract to $1.14 billion,
24 suggesting that New York's spending on these

1 services for the next three years will be
2 roughly equal to what it spent over the
3 previous nine years.
4 Especially given the severe crisis
5 that we currently face -- and we've been
6 talking about all morning -- in Medicaid
7 funding, which puts many vulnerable enrollees
8 at risk of limited or reduced services, the
9 lack of competition or even oversight for
10 these massive contracts raises very serious
11 concerns.
12 We know that there's been a history of
13 New York overpaying Maximus on at least one
14 of these contracts. Audits by the OSC of
15 MAXIMUS's New York State of Health customer
16 service contract in 2014 and '15 found that
17 New York was paying the company excessive
18 profit fees. It also found billing abuses
19 such as Maximus charging the state to put
20 employees up at $595 a night deluxe hotels,
21 and charging fringe benefit rates of
22 86 percent for some employees.
23 Nationally, we also know that Maximus
24 reports an 18.8 percent profit on its state

1 contracts. New York State is MAXIMUS's
2 largest state client -- largest state
3 client -- accounting for fully one-third of
4 its state business. This profit rate is
5 almost double MAXIMUS's profit rate on its
6 federal contracts, and seven times larger
7 that on its non-U.S. business.
8 Given the absence of competition and
9 OSC oversight and the circumvention of all
10 regular contract oversight procedures, what
11 measures is DOH taking to ensure that Maximus
12 is not abusing its contracts with New York
13 State and is earning a reasonable rather than
14 an excessive profit?
15 MEDICAID DIRECTOR FRESCATORE: So I'll
16 be happy to respond to that, Senator. I
17 think as you know, in a couple of places
18 there was state legislative authority to be
19 able to extend a contract for existing
20 services.
21 CHAIRWOMAN KRUEGER: Just put the mic
22 a little closer.
23 MEDICAID DIRECTOR FRESCATORE: Sure.
24 SENATOR BIAGGI: And can you start

1 over? Because it's very hard to hear you.
2 MEDICAID DIRECTOR FRESCATORE: Yup.
3 Is that better?
4 SENATOR BIAGGI: Yes.
5 MEDICAID DIRECTOR FRESCATORE: So as
6 you noted, Senator, there's been provisions
7 in state law that have allowed the department
8 to extend the agreement for certain services
9 and contracts -- in this case, contracts that
10 were provided by Maximus -- in order to
11 continue services to consumers and to meet
12 time frames.
13 The one contract that you noted in
14 particular was related to the standing up of
15 the New York State of Health marketplace,
16 particularly given the very short time frame,
17 and that Maximus was doing customer services
18 already.
19 SENATOR BIAGGI: I got that. But
20 how -- just let me -- let me just -- I want
21 to get to the point, because our time is
22 running and I have one more question and I
23 really want to make sure I ask it.
24 How are you ensuring that we're not

1 abusing -- that they are not abusing their
2 contracts with New York State and that their
3 profit is actually reasonable and not
4 excessive? Because considering how much
5 we're paying them, in a year where we have a
6 $6.1 billion deficit, that seems excessive.
7 And I think any New Yorker, whether
8 they're a millionaire, a billionaire or
9 middle class, low income -- it doesn't make a
10 difference -- I think every person would
11 agree that's a very high number for a
12 contract.
13 MEDICAID DIRECTOR FRESCATORE: So let
14 me address that quickly so you can get your
15 other question in.
16 SENATOR BIAGGI: Yup.
17 MEDICAID DIRECTOR FRESCATORE: We
18 certainly have been very mindful of the
19 recommendations of the Office of State
20 Comptroller. As a result, we have made
21 changes in how the contract operates and how
22 it is built, including a reduction in the
23 profit that's allowable under those
24 contracts. Since 2016, the Office of State

1 Comptroller has had no findings on their
2 review of those contracts.
3 SENATOR BIAGGI: Okay, let me just
4 stop you there. Thank you for answering that
5 question.
6 Is there a reason specifically for
7 singling out MAXIMUS's contracts without
8 competition or oversight? Why just them?
9 MEDICAID DIRECTOR FRESCATORE: I think
10 as I stated earlier, the contract -- it was
11 an extension of work that was already being
12 done, and the time frames to implement were
13 very short in order to stand up the
14 marketplace.
15 So we are -- I'm happy to talk about
16 this more offline, and we are aware of the
17 report about --
18 SENATOR BIAGGI: I don't want to talk
19 about it offline, because I would like for it
20 to be -- I'm a very transparent person, so I
21 want to make sure that everybody knows.
22 MEDICAID DIRECTOR FRESCATORE: Okay.
23 But if I could just finish, because I think,
24 you know, you also referred to some of the

1 concerns that were raised in a recent report
2 about MAXIMUS's operations in other states.
3 So we've reviewed that report as well,
4 and we are committed to ensuring that, you
5 know, that any contract that we hold is --
6 you know, the terms of it are fair and
7 responsible and in the interests of not only
8 consumers but the taxpayers. So we are
9 reviewing that report.
10 The services Maximus provides for
11 New York are different than in those other
12 states, but nevertheless it's important
13 information, and we are reviewing it.
14 SENATOR BIAGGI: Thank you.
15 CHAIRWOMAN KRUEGER: I think this is
16 one of those areas where -- I'm sorry. As I
17 announced earlier, I think this is one of the
18 areas where we would like some of those
19 questions that were thrown at you responded
20 to in writing to the chairs.
21 MEDICAID DIRECTOR FRESCATORE: And I
22 believe that those responses are in process,
23 if they've not already been sent out.
24 CHAIRWOMAN KRUEGER: Thank you.

1 Okay, Assembly.
2 CHAIRWOMAN WEINSTEIN: We've been
3 joined by Assemblyman Abinanti, and we go to
4 Assemblyman Charles Barron now for some
5 questions.
6 ASSEMBLYMAN BARRON: Thank you.
7 Commissioner, I'm sure you will agree
8 with me that we live in a racist, parasitic,
9 predatory capitalist system that uses
10 healthcare as a profit. As a matter of fact,
11 most of the profit -- high profits during
12 whether it's Obamacare or Trumpcare, the
13 private health insurance companies are
14 laughing their way to the bank.
15 And the prior speaker just raised a
16 question around contracts. I resent that
17 every year when this state has a deficit, we
18 look at Medicaid. Medicaid, $23 billion. In
19 a $178 billion State Budget, we pick on
20 Medicaid. And then you use the term
21 "savings." Why don't you say it -- what it
22 is? It's cuts. It's cuts. But you all use
23 cute language like "savings." The Medicaid
24 Redesign Team is going to come up with

1 savings. Those are cuts. Those are cuts in
2 a budget that's giving out multi-billion-
3 dollar contracts. Those are cuts in a budget
4 where the developers get subsidies, billions
5 of dollars of subsidies, to make money and
6 they call -- when they get free money, it's
7 subsidies. When we get free money, it's
8 welfare. Well, we're all on subsidies or
9 we're all on welfare.
10 So my question to you is about
11 Medicaid. We need to stopping targeting
12 Medicaid to balance the budget when
13 80 percent of the hospitals in black and
14 brown struggling communities count on
15 Medicaid. In the more affluent white
16 communities, they have private health
17 insurance.
18 So when you focus on Medicaid and
19 continue to cut Medicaid like we're doing
20 every year, we have a major problem. I'll be
21 glad when we finally pass the New York State
22 Health Act, the New York Health Act, where we
23 have Medicare/Medicaid for all and where
24 healthcare is free. Struggling countries do

1 it. Countries in Africa, countries in the
2 Caribbean, countries in Latin America,
3 countries in Europe have free healthcare.
4 And here in the richest country on the
5 planet, we can't carve out any free
6 healthcare for our people.
7 So I'll be glad when we do pass the
8 New York Health Act, which will provide
9 healthcare for all, and it will bring down
10 premiums, bring down copayments, and make it
11 more viable.
12 Everybody in this state, human beings
13 deserve, they have a right to affordable,
14 quality healthcare. And all of this nonsense
15 around budget time focusing on cutting
16 Medicaid is a disservice to this state.
17 So I want you to reconsider language,
18 and the mission for the redesign team should
19 not be savings. We need more. And the
20 reason why it's not just long-term care
21 that's causing the rise of Medicaid to go up,
22 people are becoming poorer and poorer, so
23 they need it. You want to bring down
24 Medicaid, bring down poverty and give us the

1 right to have healthcare.
2 COMMISSIONER ZUCKER: So I appreciate
3 your thoughts. And I will say that we have
4 18 million people out of 19-plus million
5 people in this state who are covered under
6 insurance, whether it's Medicaid or New York
7 State of Health. And I think that as I
8 mentioned before --
9 ASSEMBLYMAN BARRON: But since my time
10 is tight, when you say "are covered,"
11 premiums, copayments are still very, very
12 high. So people may be covered, but some --
13 and it doesn't cover everything. The
14 New York Healthcare Act is universal, it's
15 single payer, and it covers everything. And
16 it will bring the costs down for everything
17 in this state.
18 So when you say people are covered,
19 that's the same thing they say nationally,
20 people are covered. Try going to your
21 dentist and use your healthcare and see what
22 the dentist says, if you think they're so
23 covered. So that's not even adequate.
24 COMMISSIONER ZUCKER: I do feel that

1 with regards to when you're saying that we're
2 focused on Medicaid. But we are looking at
3 the entire budget. Medicaid is a large part
4 of this State Budget, of the Department of
5 Health budget, and so the --
6 ASSEMBLYMAN BARRON: Well, that's
7 because we have a lot of poor people, that
8 this state allows poverty to happen.
9 You know, there's 30 and 40 percent
10 poverty in black and brown communities in
11 New York City and across this state. So once
12 you allow that kind of poverty, you're going
13 to have a need for Medicaid.
14 COMMISSIONER ZUCKER: And one of the
15 things that we are looking at is all these
16 other social determinants of health. So you
17 bring up the issues of poverty, housing,
18 nutrition, all these other areas. And these
19 are some of the areas that the Governor has
20 addressed on some of the Health Across All
21 Policies --
22 ASSEMBLYMAN BARRON: Like Martin
23 Luther King said, maybe it's time for America
24 to move to more of a socialist economy than a

1 capitalist one.
2 CHAIRWOMAN WEINSTEIN: And with that
3 note, we go to the Senate.
4 CHAIRWOMAN KRUEGER: I don't think I
5 saw that in the Governor's Budget, Charles,
6 but thank you for that proposal.
7 Excuse me. Our next is Robert
8 Jackson.
9 SENATOR JACKSON: So good afternoon.
10 COMMISSIONER ZUCKER: How are you.
11 SENATOR JACKSON: It's a great day in
12 New York, right?
13 COMMISSIONER ZUCKER: Always is. The
14 sun is shining.
15 SENATOR JACKSON: Well, let me thank
16 you for coming in front of us.
17 So people talk about the -- in 2011
18 the Governor created the MRT team, and
19 there's a cap. So how come the cap is not
20 realistic? Why don't we get rid of that cap
21 and do what's realistic as far as providing
22 all of the people on Medicaid the type of
23 health coverage that they need?
24 COMMISSIONER ZUCKER: Well, I think

1 one part of it -- and Donna could chime in --
2 one part is that MRT did do what it was
3 supposed to do, it did move forward on
4 addressing many of the challenges that we did
5 have. That was 2011, 2012.
6 And now we're in 2020, things have
7 changed. The issues that we're facing are
8 different. And we've heard about it from
9 your esteemed colleagues that there are other
10 issues that we're facing, whether it's home
11 care, long-term care, and that we need to,
12 when we do MRT II, address some of those as
13 well.
14 But Donna, did you want to add
15 anything?
16 SENATOR JACKSON: But Commissioner, is
17 there still that cap from before? That's the
18 question. And if the answer is yes, why are
19 we dealing with a cap that was put in place a
20 long time ago and not realistically what we
21 need today?
22 COMMISSIONER ZUCKER: Well, we look
23 at -- MRT II, we'll look at --
24 SENATOR JACKSON: So first of all, is

1 there still the cap?
2 COMMISSIONER ZUCKER: Well, there is
3 the cap. And we will look at --
4 SENATOR JACKSON: So that cap has been
5 there for how long?
6 COMMISSIONER ZUCKER: Well, from 2011.
7 SENATOR JACKSON: Come on, that's
8 unrealistic. Don't you agree?
9 COMMISSIONER ZUCKER: Well, we need to
10 look at --
11 SENATOR JACKSON: No, I'm asking you a
12 question. Do you agree that's unrealistic
13 from 10 years ago?
14 COMMISSIONER ZUCKER: No, I think that
15 the purpose of what the cap achieved was
16 control of the spending that
17 was skyrocketing --
18 SENATOR JACKSON: But that was then,
19 Commissioner. We're talking about now.
20 COMMISSIONER ZUCKER: Right. Well,
21 now, this is why the Governor has put forth
22 the goal to have an MRT II to look at all the
23 issues that we have. The MRT I, if we want
24 to call it that, achieved the goals that were

1 set forth at that time. And so now we will
2 look at this. And it is an evolving process.
3 And many of the things that were raised here
4 are the things that we will need to address.
5 SENATOR JACKSON: And I'm glad. But
6 that -- my understanding is that if the MRT
7 team comes with the fact that if we don't
8 accept, then there's going to be a
9 $2.5 billion cut and there will be layoffs,
10 is that correct, if in fact we don't agree
11 with it? Based on your knowledge?
12 COMMISSIONER ZUCKER: I'm not saying
13 that. I'm saying that we need to look at all
14 the -- everything is sort of on the table as
15 we move forward from here.
16 SENATOR JACKSON: Let me express to
17 you the concerns. I had a meeting at
18 Isabella Geriatric Center in my district with
19 a thousand 1199 employees that are very
20 concerned about the survival of institutions
21 like Isabella and other nursing homes that
22 provide services for the needy, okay, and
23 they're concerned about the lack of funding,
24 and possibly layoffs.

1 Are you concerned about that, there
2 may be layoffs if in fact MRT team No. 2
3 comes with a situation that's unacceptable to
4 the State Legislature?
5 COMMISSIONER ZUCKER: I think we're --
6 you're making some predictions which are not
7 necessarily to be the case at all. No one
8 wants to cause anything that will jeopardize
9 the care of those in New York, whether it's
10 in nursing homes or hospitals. And so we --
11 we need to look at how to do this, how to
12 move things forward, how to be even more
13 efficient than perhaps we have been, and how
14 to make sure that the services continue to be
15 provided.
16 But it may be that -- you know,
17 sometimes everyone says, well, it's all about
18 just money. But the reality is that when we
19 look at providing services, sometimes it's
20 figuring out how to be more efficient and
21 doing things differently. And we've done
22 that over the course --
23 SENATOR JACKSON: Without decreasing
24 services, though, is that correct?

1 COMMISSIONER ZUCKER: Right,
2 without -- of course without decreasing
3 services, right. Just to be more efficient
4 and figure out maybe there's a way to do
5 this. And I think that we have to look at it
6 that way.
7 SENATOR JACKSON: Now, there's a
8 caveat for New York City, right, if New York
9 City -- what is that cap? If not, then
10 there's cost factors going to have to be
11 observed by localities.
12 MEDICAID DIRECTOR FRESCATORE: So
13 there's not a separate New York City cap,
14 Medicaid global spending cap, it's an overall
15 cap.
16 And just to answer your question,
17 Senator, yeah, the cap remains in place, it's
18 a rolling increase. So every year it goes
19 up. The issue is whether or not it's gone up
20 enough to cover the cost of increases in
21 care, our aging population. Remember, it's
22 been tremendously successful. We reduced the
23 number of uninsured immensely -- I mean, a
24 million more -- more than a million

1 additional people got Medicaid under this
2 cap.
3 But the question is, and I think what
4 you're raising, is it's time to look at the
5 cap again, right? A number of years has gone
6 by. And I think that -- I look at the cap as
7 a tool, a metric, to look at how spending is.
8 But I think --
9 SENATOR JACKSON: Director --
10 director --
11 MEDICAID DIRECTOR FRESCATORE: -- the
12 metric itself is up for discussion.
13 SENATOR JACKSON: Director, I
14 apologize, I've got only 15 more seconds.
15 My question is this with respect to --
16 so every year that cap has been exceeded, is
17 that correct? And that's why we had the
18 $1.7 billion deficit from last year?
19 MEDICAID DIRECTOR FRESCATORE: It has
20 not been exceeded every year. But that year
21 it was exceeded. There were some years it
22 was not exceeded.
23 SENATOR JACKSON: So why is it that we
24 have a $6.2 billion deficit and 4 billion of

1 that is Medicaid, then?
2 MEDICAID DIRECTOR FRESCATORE: For
3 reasons I think that we kind of outlined
4 before, including enrollment increases,
5 including more long-term-care services,
6 including Medicaid's appropriate share of
7 paying minimum wage for healthcare workers.
8 It's for what we enumerated.
9 But we would agree that with -- you
10 know, 10 years has gone by, almost, and that
11 we should be looking at the cap again. And
12 we think that, you know, that's one of the
13 reasons to reconvene this group, to say is
14 that the right metric to still be looking at.
15 SENATOR JACKSON: Thank you. Thank
16 you, Madam Chair.
17 CHAIRWOMAN KRUEGER: Thank you.
18 Assembly.
19 CHAIRWOMAN WEINSTEIN: We go to
20 Assemblyman Blake.
21 ASSEMBLYMAN BLAKE: Good afternoon.
22 On your New York State Health Equity
23 Report of April 2019, on page 5 -- and this
24 is for context and reference before going

1 into today -- you indicate: "The report
2 indicated that blacks and other minorities
3 accounted for 60,000 excess deaths each year
4 and identified six causes of death that
5 represented more than 80 percent of mortality
6 among racial and ethnic minorities compared
7 to whites." That's from your own report,
8 Commissioner.
9 We would acknowledge that there are
10 disparities when it comes to communities of
11 color. Would that be accurate?
12 COMMISSIONER ZUCKER: I'd agree.
13 ASSEMBLYMAN BLAKE: Can you convey the
14 intent of the DSRIP program, Commissioner?
15 COMMISSIONER ZUCKER: The intent --
16 ASSEMBLYMAN BLAKE: DSRIP.
17 COMMISSIONER ZUCKER: Yes, what
18 about -- what is your specific question about
19 DSRIP?
20 ASSEMBLYMAN BLAKE: Can you explain to
21 everyone what is the intent of DSRIP?
22 COMMISSIONER ZUCKER: Well, the DSRIP
23 program was to -- one of the key things here
24 was to decrease hospital readmissions and

1 decrease use of emergency rooms. And -- and
2 if -- we also put out a report that gave
3 examples of the success of the DSRIP program
4 with specific examples of that.
5 ASSEMBLYMAN BLAKE: Understand. Just
6 one question. What was the dollar amount of
7 the first DSRIP program?
8 COMMISSIONER ZUCKER: I have to --
9 Donna, do you know that?
10 ASSEMBLYMAN BLAKE: Was it essentially
11 $8 billion?
12 MEDICAID DIRECTOR FRESCATORE: It
13 was -- it was roughly that, 8 billion federal
14 dollars given to reinvest. You're exactly
15 right.
16 ASSEMBLYMAN BLAKE: How much of that
17 $8 billion went to community-based health
18 centers to address the concerns of
19 communities of color?
20 COMMISSIONER ZUCKER: So I know this
21 question comes up about the fact that most
22 things went to hospitals --
23 ASSEMBLYMAN BLAKE: (Overtalk.)
24 COMMISSIONER ZUCKER: I don't have the

1 exact number, but I recognize that the
2 feelings that the community health centers
3 and just community health is something which
4 many people feel is not being addressed as
5 much.
6 But we have, in the course of the last
7 five, six, seven, eight years --
8 ASSEMBLYMAN BLAKE: I understand.
9 COMMISSIONER ZUCKER: -- we have
10 recognized that there is a move, obviously,
11 towards more of community health. And we
12 will work towards achieving the goals of what
13 you're asking --
14 ASSEMBLYMAN BLAKE: So very
15 specifically, there is a DSRIP II that is
16 currently enacted --
17 COMMISSIONER ZUCKER: Yes.
18 ASSEMBLYMAN BLAKE: Correct. Have you
19 submitted community-based health centers in
20 that current proposal?
21 MEDICAID DIRECTOR FRESCATORE: We've
22 not submitted any providers or types of
23 organizations in that current proposal.
24 What we did do, though, was we laid

1 out a new structure where community-based
2 organizations must be part of the governance
3 of health -- population health entities.
4 And we've also requested from the
5 federal government funding for a new program,
6 the Social Determinant of Health Networks --
7 ASSEMBLYMAN BLAKE: Understand.
8 MEDICAID DIRECTOR FRESCATORE: -- that
9 would be led by community-based
10 organizations. DSRIP has given us an ability
11 that we didn't have before --
12 ASSEMBLYMAN BLAKE: Absolutely. So --
13 MEDICAID DIRECTOR FRESCATORE: --
14 which was to use Medicaid dollars to work on
15 housing and hunger and literacy, right?
16 ASSEMBLYMAN BLAKE: Absolutely. So
17 just for clarity, in the first $8 billion,
18 community-based health centers were not
19 included in that. And currently, as of now,
20 there's a current consideration, but it's not
21 clear how that will be defined. I'll put a
22 pin in that.
23 Can you -- are you aware of the
24 Diversity in Medicine program that we have

1 here in New York State?
2 COMMISSIONER ZUCKER: I do, yes.
3 ASSEMBLYMAN BLAKE: Is there a reason
4 given -- that your own data that you all, in
5 terms of the Governor's administration,
6 propose zeroing out that program?
7 COMMISSIONER ZUCKER: Well, so I just
8 want to say that there is a commitment to the
9 issues of diversity in medicine across the
10 board --
11 ASSEMBLYMAN BLAKE: Very specifically,
12 can you just rationalize, given your own
13 data, why did you propose zeroing out the
14 Diversity in Medicine program?
15 COMMISSIONER ZUCKER: Well, we were
16 looking to -- obviously, tough fiscal times,
17 and we were looking at all the programs and
18 figuring out is there somewhere else that
19 there could be the needs met that those
20 programs provide. And we are -- we are
21 trying to move that forward.
22 ASSEMBLYMAN BLAKE: Commissioner,
23 let's go a step back. And I know time is
24 tight.

1 Your own report from April 2019 said
2 80 percent of higher excess deaths were
3 happening among communities of color. But
4 you all proposed eliminating completely
5 funding for the Diversity in Medicine
6 Program. Second, and a part of that,
7 community-based health centers, which, as you
8 would know as a medical professional,
9 overwhelmingly there would be higher
10 likelihood of helping communities of color.
11 I'm just trying to understand, why
12 would that be the approach, given the data?
13 COMMISSIONER ZUCKER: So I understand.
14 Like I said, these were challenges that we
15 were faced with. But when we looked at those
16 challenges, we sort of said, are there other
17 areas where some of the needs are met? For
18 example, the maternal mortality program,
19 which --
20 ASSEMBLYMAN BLAKE: Is there any other
21 funding area for diversity in medicine --
22 COMMISSIONER ZUCKER: Right, well, so
23 I'm going to bring up diversity in medicine
24 in general. One of the big issues that came

1 out of the maternal mortality listening
2 sessions was that the reason there's
3 disparities between the African-American
4 population and white population when it comes
5 to OB-GYN was there isn't enough diversity --
6 ASSEMBLYMAN BLAKE: Understand.
7 COMMISSIONER ZUCKER: -- in there, and
8 so we said, okay, let's see how can we move
9 that forward as the -- as a result of the
10 discussions we had.
11 So it's not like just because
12 something's not on that line, it's not being
13 addressed elsewhere.
14 ASSEMBLYMAN BLAKE: Commissioner, you
15 and I have been in part of many conversations
16 over the years. I think we can both
17 appreciate when you zero out a line item,
18 that's conveying a sense of priority.
19 So coming from the Bronx, which has
20 been the most unhealthy county in New York
21 State --
22 COMMISSIONER ZUCKER: I lived there.
23 ASSEMBLYMAN BLAKE: -- it is
24 perplexing to me that you would zero out the

1 Diversity in Medicine Program as well as not
2 have a clear indication on what's happening
3 in our community-based health centers. And
4 it would be our expectation you all will
5 resolve that when the budget is finalized.
6 Thank you.
7 CHAIRWOMAN WEINSTEIN: Senate?
8 CHAIRWOMAN KRUEGER: Thank you.
9 Senator Pat Ritchie.
10 SENATOR RITCHIE: Commissioner, I have
11 two questions for you. The first one is a
12 question that I believe we spoke about last
13 year, and that's the shortage of rural
14 doctors and nurses, especially in the North
15 Country.
16 So I'm wondering what has been done in
17 the last year or what is the plan to address
18 it. Because we're at the point now where in
19 some hospitals, beds are not being opened
20 because of the shortage.
21 And the second one is on the critical
22 status of our nursing homes. Over the nine
23 years I've been in here, I've had a number of
24 nursing homes who have closed. And when they

1 closed, the remaining ones were financially
2 stable. We're now at the point where the
3 ones that were financially the strongest,
4 they're calling on a regular basis saying
5 that they're in the red and many times they
6 can't make payroll. And that's something
7 that's so important to our communities.
8 So I'm just wondering, on those two,
9 what is the plan?
10 COMMISSIONER ZUCKER: So on the first
11 one, with rural health, as I mentioned
12 before, this is a priority of the department.
13 We have been working in the North Country
14 particularly about how to address some of
15 these challenges, and particularly in the
16 areas where someone could drive 50, 60 miles
17 until they get to a physician, let alone
18 perhaps the physician is a subspecialty
19 physician to the need that they particularly
20 have. And so we are working on that.
21 I believe that the model of what we
22 are doing in the North Country will be able
23 to be replicated elsewhere -- not just here,
24 but it will be a model for the rest of the

1 nation, I believe.

2 So that's one part. And we are aware

3 of these challenges and we're trying to

4 figure out what other things we could do to

5 get health professionals, whether it's

6 doctors, nurses, nurse practitioners,

7 pharmacists -- you can go down the list -- to

8 areas and have them stay in communities where

9 we don't presently have health professionals

10 that -- the number of health professionals

11 that we need.

12 With regards to the nursing home

13 issue, I hear you. I hear you. We have had

14 the nursing home leadership in, we have sat

15 down, I have addressed this with -- it's not

16 just nursing homes, it's this issue, I think

17 in the bigger picture of care, whether it's

18 nursing home, home care, rehabilitative

19 services. It's all the caregiving, it's all

20 of this issue of how do we provide care for

21 those who are either elderly or not even just

22 elderly, just where they have a challenge

23 that makes it difficult for them to be

24 ambulatory or able to help themselves or have

1 relatives help them.
2 So we are looking at that. And I
3 understand that this is a concern. I've
4 heard it from all the legislators today. And
5 I hear it on a regular basis. And we're
6 trying to figure out a solution. If there
7 was an easy solution to this, it would have
8 been, you know, fixed a long time ago. So we
9 are tackling it.
10 SENATOR RITCHIE: I appreciate that.
11 And, you know, for me it makes it really
12 concerning that the ones that had no problems
13 a couple of years ago, that really were the
14 stand-up institutions in the area, now are
15 the ones calling saying "We can't make
16 payroll." So something's got to be done.
17 COMMISSIONER ZUCKER: I know.
18 SENATOR RITCHIE: Thank you.
19 CHAIRWOMAN KRUEGER: Thank you.
20 Assembly.
21 CHAIRWOMAN WEINSTEIN: Assemblywoman
22 Rosenthal.
23 ASSEMBLYWOMAN ROSENTHAL: Thank you,
24 Madam Chair.

1 Hello. I have a bunch of questions,
2 so I'm going to ask quickly. 2019, a bill I
3 passed into law requiring Department of
4 Health to distribute a booklet about
5 lymphedema to patients at high risk of
6 developing it. It's been a year, and that
7 hasn't been done. So please put that down on
8 your list to do.
9 COMMISSIONER ZUCKER: Yup.
10 ASSEMBLYWOMAN ROSENTHAL: Secondly,
11 I'm chair of the Committee on Alcoholism and
12 Drug Abuse, and what I see in this year's
13 proposed budget is shameful. People continue
14 to die. People continue not to have access
15 to Narcan, to buprenorphine, to any of those
16 life-saving drugs that will keep people out
17 of the streets to obtain drugs and will allow
18 them to try to resume their lives.
19 Yet there are so many hurdles. The
20 Governor vetoed a bill of mine eliminating
21 prior authorization for people on Medicaid,
22 yet he signed one on commercial prior
23 authorization, eliminating that. You can
24 quibble over provisions of the bill that

1 perhaps were not satisfactory, but the point
2 remains that we have an opioid overdose
3 crisis in this state, and it's shameful that
4 we are not paying the attention that it
5 deserves. Because it's about people's lives,
6 and we are losing their lives.
7 So that's one statement.
8 One question for you is some years ago
9 in the booklet End AIDS By 2020, there was a
10 provision that the government supports the
11 establishment of opioid overdose centers.
12 Philadelphia has gone ahead, they've gone to
13 court, they're still grappling in the courts,
14 and we here in New York State, who pride
15 ourselves on being first in the nation, are
16 still quibbling about this issue.
17 This is a proven method of keeping
18 people alive and helping them get to
19 treatment if they are ready, and yet all we
20 do is push out press releases about how we're
21 making advances, but in fact we are not.
22 COMMISSIONER ZUCKER: So I'm glad
23 you're bringing this up, because I think
24 there's some points that you make that -- and

1 I want to just clarify, is that in 2019 is
2 the first year that New York State actually
3 has a decrease in the number of opioid
4 deaths. And we have made an incredible
5 effort on this issue. The Governor has had
6 in his -- the proposed new initiatives, in
7 addition to all that we've been doing. We've
8 got about half a million individuals in the
9 state who are trained to administer Narcan.
10 We have worked across the state on this.
11 I've heard stories about people who have
12 saved individuals.
13 ASSEMBLYWOMAN ROSENTHAL: Does
14 everybody who has an overdose and gets taken
15 to the hospital, once they're able to leave,
16 do they get Narcan or do they get
17 buprenorphine? Every single emergency room.
18 COMMISSIONER ZUCKER: So we've --
19 they've received Narcan at the hospital. But
20 we have worked at leading the nation on
21 trying to get buprenorphine into physicians'
22 offices so they don't have to actually go
23 to --
24 ASSEMBLYWOMAN ROSENTHAL: Trying to?

1 But what has happened?
2 COMMISSIONER ZUCKER: Well, we have
3 pushed forward on this, and we have had --
4 we've led and got 24 other states to write to
5 the federal government and sort of say that
6 this is something that needs to be done,
7 there's certain rules that have to be changed
8 on that.
9 But we have banned, the Governor has
10 banned the fentanyl analogs, we have
11 addressed the medication-assisted treatment
12 programs that are out there. I --
13 ASSEMBLYWOMAN ROSENTHAL: Wait, wait.
14 Addressed?
15 COMMISSIONER ZUCKER: Well, I will
16 tell you that what we have done is that we
17 have established a buprenorphine prescription
18 voucher -- I'll read through this program --
19 that provides a seven-day emergency supply of
20 medication-assisted treatment as a bridge to
21 insurance coverage. That's one of the things
22 done.
23 We are connecting the emergency
24 departments with doctors who can prescribe

1 buprenorphine through telehealth. That's the
2 second thing we've done.
3 ASSEMBLYWOMAN ROSENTHAL: Wait. Is
4 that in every emergency room where that's
5 needed?
6 COMMISSIONER ZUCKER: We are moving
7 towards that for every emergency room.
8 ASSEMBLYWOMAN ROSENTHAL: So when
9 would that happen?
10 COMMISSIONER ZUCKER: We're moving --
11 these are some of the things that we want to
12 do to move forward on this as the Governor's
13 proposals for new initiatives this year on --
14 when it comes to this. We are working to
15 propose a single formulary for Medicaid that
16 will ensure access to MAT that will be
17 granted quickly and efficiently. We are
18 working with the correction facilities so
19 that when someone leaves a correction
20 facility, there isn't a -- there's a seamless
21 transition of care. Often what happens is
22 someone leaves and if they're not tied into
23 the system, then --
24 ASSEMBLYWOMAN ROSENTHAL: I'm quite

1 familiar with that. And in the Governor's
2 proposed budget, a million dollars was cut
3 from money to the counties to actually
4 implement that.
5 COMMISSIONER ZUCKER: But we are
6 working -- we are working with the counties,
7 we're working with the hospitals. Staten
8 Island is one of the areas where there's been
9 some of the challenges. We've been out there
10 working with Staten Island. We're working
11 across the system to address this.
12 On the Narcan issue --
13 ASSEMBLYWOMAN ROSENTHAL: It is too
14 slow. People are dying. And we know some of
15 the solutions to keeping people alive. And
16 writing letters and demanding changes is all
17 very well and good, but as the chair of the
18 committee who deals with people and groups
19 and advocates, it's like enough "trying to."
20 There are ways to implement and not try.
21 Just do it.
22 COMMISSIONER ZUCKER: But we have --
23 we have implemented things --
24 ASSEMBLYWOMAN ROSENTHAL: No, no,

1 you've done some things, but there are so
2 many things that have not been done that
3 don't get enough attention in the budget.
4 And it's reprehensible that in New York State
5 we're allowing people to be homeless on the
6 streets, addicted to certain drugs, and not
7 have anywhere to go to make themselves
8 better.
9 CHAIRWOMAN WEINSTEIN: Thank -- thank
10 you. To the Senate.
11 CHAIRWOMAN KRUEGER: (Mic off.) We're
12 taking a leap it's another 45 minutes of
13 questions. Do you wish to have a human needs
14 break?
15 COMMISSIONER ZUCKER: I'm fine.
16 Donna, you good?
17 CHAIRWOMAN WEINSTEIN: Stretch your
18 legs?
19 CHAIRWOMAN KRUEGER: You're okay?
20 okay.
21 So actually, I'm up next. But you
22 turned down the chance to get out of the room
23 for a minute.
24 (Laughter.)

1 COMMISSIONER ZUCKER: What if we
2 didn't come back?
3 (Laughter.)
4 CHAIRWOMAN KRUEGER: Well, there's the
5 challenge. We have guards that wouldn't let
6 you off the floor, not to worry.
7 (Laughter.)
8 CHAIRWOMAN KRUEGER: Sorry.
9 So actually Assemblymember Blake asked
10 you about DSRIP issues. My understanding is
11 that somewhere in the budget it actually says
12 the three years we're still owed for federal
13 money for DSRIP that localities, I'm
14 assuming, already spent and are just waiting
15 to get back to you, that there's some kind of
16 taking back that money, and that the State
17 Budget is wiping out your obligation to make
18 good on the past DSRIP payments.
19 Do you see anything in the budget that
20 says that?
21 MEDICAID DIRECTOR FRESCATORE: Yeah,
22 that's not ringing a bell, Senator. I mean,
23 there -- I'm happy to take a look. I
24 apologize if I'm just not recognizing it.

1 It's localities and DSRIP, is that the
2 concern? Or was it the enhanced federal
3 match in the localities, perhaps?
4 CHAIRWOMAN KRUEGER: I don't know. So
5 it was asked of me as a question, so I'm
6 asking you to check for me --
7 MEDICAID DIRECTOR FRESCATORE: I will
8 do that.
9 CHAIRWOMAN KRUEGER: -- whether there
10 is previous years' federal money that we have
11 yet to get that we believe up until now is
12 owed to localities. And is there anything in
13 this year's budget that changes that story
14 line so, if and when the feds pay us, we're
15 not paying it to the localities and the
16 providers?
17 MEDICAID DIRECTOR FRESCATORE: Okay, I
18 apologize, but it's just not ringing a bell.
19 So we can talk about that. If you'll send us
20 some more information, I'll be certain we
21 look into it promptly.
22 CHAIRWOMAN KRUEGER: Thank you.
23 There was also some discussion about
24 the Maximus contracts which we're all very

1 interested in learning more about. But I
2 wanted to point out, when we're talking about
3 the localities and their ability to impact or
4 not impact how much is being spent in
5 Medicaid and eligibility, in New York City
6 it's Maximus that decides how many hours
7 you're going to get in long-term care. Yes,
8 they determine the number of hours. After
9 you're approved for Medicaid, then you go to
10 the Maximus and they determine the estimated
11 number of hours. Then it goes to the care
12 provider, who can argue it.
13 But so, again, how is it the locality
14 controlling this?
15 MEDICAID DIRECTOR FRESCATORE: Yeah,
16 so let me explain how the process works. So
17 an individual, say, for example, a person
18 who's eligible for Medicare and Medicaid, a
19 dual-eligible, say they're not in Medicaid
20 currently but they have a healthcare episode
21 that requires that they're going to need some
22 home care.
23 They would go to their local district,
24 and they would apply for Medicaid. They

1 would have to have, under regulation, a
2 doctor's order that says they need help in
3 their home, particularly, you know, with
4 activities of daily living. And the local
5 district would do a nursing assessment and a
6 social assessment. And based on the
7 results -- and that's what's in regulation --
8 based on the results, the local district
9 would develop a plan of care for that
10 individual.
11 Conversely, if that individual was
12 already in a managed-care plan at the time
13 they developed need for long-term-care
14 services, their service plan would be
15 developed by the managed-care plan.
16 Maximus doesn't develop or decide a
17 number of hours. There is a conflict-free
18 process that Maximus administers, sometimes
19 referred to as CFEEC, is the acronym you'll
20 hear. That process is not setting the care
21 plan. It is -- it's a determination that the
22 individual is in fact meeting the threshold
23 need for long-term care, which is 120 days of
24 continuous home care services.

1 So Maximus does not determine Medicaid
2 eligibility, they don't decide who is
3 eligible and who is not, and they don't
4 develop the care plan once someone is
5 determined to need long-term care.
6 And I know it's different avenues
7 depending on where people start off.
8 CHAIRWOMAN KRUEGER: I understand --
9 right. The county decides if you're
10 eligible, there's no eligibility options for
11 the counties, it's the state's rules.
12 And then at least for the city, which
13 used the majority of long-term-care dollars,
14 I believe, it goes through Maximus to
15 determine whether or not you're going to be
16 eligible.
17 MEDICAID DIRECTOR FRESCATORE: No, in
18 fact when we look at the statistics from
19 current data, what we see -- and I had given
20 the statewide statistics earlier, about
21 400,000 people in New York City are receiving
22 either personal care or consumer-directed
23 care. And the care plans and number of hours
24 for those individuals are determined by the

1 Health Resources Administration. That is a
2 duty of the local social services district
3 for the people who are in fee-for-service.
4 CHAIRWOMAN KRUEGER: So in the MRT,
5 which has also been brought up a number of
6 times, and concerns about that, the Governor
7 announced there will be two people
8 cochairing, I guess. One is the retired head
9 of 1199, and one is the current head of the
10 largest hospital system in the State of
11 New York.
12 Do you find it to be a conflict of
13 interest for the person who's the head of the
14 largest hospital system in the State of
15 New York to be the one deciding where
16 Medicaid cuts are going to go or not go?
17 COMMISSIONER ZUCKER: Well, I'll
18 respond and say that I believe that -- that
19 they can separate their interests of --
20 their -- well, you're specifically focusing
21 on the hospital system -- separate their
22 interests that -- from the system that
23 they're doing and then look at the issue, the
24 bigger picture of Medicaid reform.

1 CHAIRWOMAN KRUEGER: Hmm. I would
2 assume they have a contract that makes them
3 be fiduciarily responsible to the best
4 interests of their healthcare system. Not
5 having seen the contract.
6 COMMISSIONER ZUCKER: Well, they're
7 the chairs, and there will be a whole
8 committee. And I'm sure that a lot of people
9 will provide their input as well. And I
10 think that the -- what will come out of that
11 MRT II will be a way forward. And I think
12 that the chairs will help oversee that, but
13 there will be a lot of input from many
14 others.
15 CHAIRWOMAN KRUEGER: So even though
16 that MRT hasn't gone to work yet, and we
17 don't know who else is on it -- because
18 Senator Rivera already raised that with
19 you -- there are some specific cuts in this
20 budget to MRT changes that have been in
21 effect in New York State. The one I want to
22 highlight is the Department of Health is
23 cutting the MRT supportive housing program
24 from 98 million to 26.7 million.

1 That has sort of been a star program,
2 as far as I've ever seen in the reports, that
3 we actually got medically vulnerable and sick
4 people into housing from the streets and we
5 radically reduced their use of Medicaid and
6 other healthcare funding.
7 So we're potentially going to
8 translate this into up to 1500 disabled
9 people who were homeless and were high users
10 of Medicaid -- substance abusers, HIV/AIDS,
11 chronic health issues, mentally ill -- and
12 put them back on the streets, even though we
13 didn't have MRT meeting yet again. Why is
14 that specific cut in the budget?
15 MEDICAID DIRECTOR FRESCATORE: So let
16 me see if I can address this.
17 So the current-year actions for '20
18 include $3 million for supportive housing
19 that is unspent. It's not committed. That
20 funding is -- it will remain -- it's unspent
21 money.
22 I know there's been some confusion
23 about the appropriations and the complexities
24 of how they work between the state funding

1 and the federal funding. But it is from the
2 Medicaid global cap standpoint. It is our
3 intent to have the cap continue to fund every
4 unit, every subsidy that's currently being
5 funded.
6 And if you look in the April through
7 December Medicaid Global Spending Report when
8 we forecast spending, you'll see that part of
9 the spending forecast under the global cap
10 includes the commitment to supportive
11 housing.
12 But I'll go back and see if I can get
13 some clarification, because I think the
14 appropriations structure -- that they can get
15 complicated. And I -- but it is -- again,
16 the Medicaid global cap is going to support
17 every unit subsidy that's supported
18 currently, with the exception of what's not
19 spent, and that's $3 million.
20 CHAIRWOMAN KRUEGER: And because I
21 want to make sure I heard you correctly
22 before, Director Frescatore, I believe you
23 answered a question when someone said if a
24 county goes over the cap, will they lose a

1 percentage of the Medicaid growth money from
2 the state? Will they lose all the Medicaid
3 growth money from the state? I believe you
4 answered, though, they'd lose all of it.
5 MEDICAID DIRECTOR FRESCATORE: It
6 depends on whether or not they've met the
7 property tax cap. If they live within the
8 property tax cap, and let's say, for example,
9 the Medicaid spending growth is 4 percent and
10 the allowable percentage is 3 percent, they
11 would be responsible for the 1 percent
12 differential.
13 If they came in at 2 percent, that's
14 where the sharing would occur, 25 percent of
15 the difference there.
16 CHAIRWOMAN KRUEGER: So we're asking
17 the counties, live within your property tax
18 cap, pick up additional costs in Medicaid,
19 but if you're not successful in magically
20 figuring out how to do it without going above
21 cap, we're going to take a bigger chunk of
22 money away from you.
23 MEDICAID DIRECTOR FRESCATORE: I think
24 that what the proposal does is it looks to

1 bring the local districts to the table in
2 working with all of us to find effective ways
3 to control the growth of the Medicaid
4 spending. And I'm confident we can find
5 those partnerships.
6 And there's lots of good ideals out
7 there, I believe, at the local level because
8 they are on the ground, that will allow us to
9 work in that partnership.
10 CHAIRWOMAN KRUEGER: My time is up,
11 thank you. Assembly.
12 CHAIRWOMAN WEINSTEIN: Assemblyman
13 Ashby.
14 ASSEMBLYMAN ASHBY: Thank you,
15 Madam Chair. Good afternoon, Commissioner,
16 Director.
17 Being that our counties are
18 intrinsically tied to Medicaid through
19 coordination of services, delivery of
20 services and funding, and our growing aging
21 population of all races and ethnicities is
22 growing tremendously as a primary population
23 using Medicaid, why wouldn't our counties and
24 long-term care have reps on MRT II? And

1 don't you think their inclusion could help
2 prevent an MRT III?
3 MEDICAID DIRECTOR FRESCATORE: My
4 recollection is that in fact there was county
5 representation on the first round of MRT.
6 I've certainly talked to the folks that --
7 our local social services commissioners or
8 county social services commissioners. They
9 expressed their interest as well. We'll have
10 more information later.
11 But again, you know, the intent of the
12 MRT is for the representation to be
13 statewide, for it to include legislative
14 representatives, as it did the first time,
15 and for it to, you know, be very broad in its
16 stakeholder perspective. So every sector of
17 the healthcare industry as well as local
18 governments.
19 ASSEMBLYMAN ASHBY: So why wouldn't we
20 see representation on MRT II right now from
21 the counties and long-term care?
22 MEDICAID DIRECTOR FRESCATORE: MRT II
23 has not been convened yet.
24 ASSEMBLYMAN ASHBY: Why wouldn't these

1 people be on it? Can you think of a reason?
2 MEDICAID DIRECTOR FRESCATORE: I --
3 we'll have -- there will be more information
4 later in this week. But what I'm saying is
5 that in the past they were on it, and --
6 ASSEMBLYMAN ASHBY: So there's no good
7 reason why we should expect they wouldn't be
8 on it this time. Is that fair to say?
9 MEDICAID DIRECTOR FRESCATORE: I --
10 I -- I'm not aware of any decision they would
11 not be part of it.
12 ASSEMBLYMAN ASHBY: Okay. Thank you.
13 COMMISSIONER ZUCKER: I think I would
14 say that the feedback that we have heard from
15 all of you is helpful as we develop the
16 MRT II. And I know Senator Rivera was asking
17 about, like, the composition. But we've sat
18 here for several hours and heard the -- your
19 concerns and interests of who should serve on
20 such a committee, and that's very helpful for
21 all of us.
22 CHAIRWOMAN WEINSTEIN: Senate.
23 CHAIRWOMAN KRUEGER: Thank you. We're
24 just double-checking.

1 Okay, to close for the Senate, second
2 round, Gustavo Rivera, chair of Health.
3 SENATOR RIVERA: Round two. It's
4 going to be a quick one.
5 First of all, this is the Medicaid
6 Global Spending Cap Report, April through
7 December of 2019. Could you explain to us in
8 a very tight nutshell why it took nine months
9 for what is supposed to be a monthly report
10 to be produced?
11 MEDICAID DIRECTOR FRESCATORE: The
12 intent of the report is to present the
13 proposed solutions to close any structural
14 deficit, and those solutions are reflected in
15 this report consistent with the --
16 SENATOR RIVERA: That's not what I
17 asked. I'm sorry, not what I asked. I said
18 why did it take nine months to produce a
19 report which should have been produced on a
20 monthly basis from March to here?
21 MEDICAID DIRECTOR FRESCATORE: And my
22 answer was that the purpose of the report, we
23 believe, is to present the solution -- if a
24 structural deficit is identified, to present

1 a solution. And it was when the solution was
2 identified that the report was produced.
3 Every month's information is contained
4 in the appendix.
5 SENATOR RIVERA: That's not an answer
6 to my question, but okay. Because you could
7 have put it out on a monthly basis. You're
8 telling us that you basically had no
9 information for nine months, but at the
10 nine-month level then you figured out that
11 you could put together nine months. That's
12 not an acceptable answer. That's number one.
13 Number two, the Governor said that
14 there were no cuts. That's what he said
15 during his budget presentation. And could
16 you tell us what the reduction and
17 consolidation of the rural health funding,
18 the discontinuing of the Health Workforce
19 Retaining Program, the discontinuing of the
20 Diversity in Medicine, the discontinuing of
21 workforce studies, and particularly just as
22 one particular one, the discontinuing of the
23 Adult Cystic Fibrosis Assistance Program,
24 which serves 70 individuals, seven-oh, and

1 saved the state $380,000?
2 I mention all that to say how can you
3 make the argument to me that those are not
4 cuts? That's number one. And number two, if
5 we're trying to close a $2.5 billion hole, is
6 it not a little silly to sit here and tell us
7 that we're going to take away something from
8 70 people that have cystic fibrosis to save
9 $380,000?
10 COMMISSIONER ZUCKER: So I think as I
11 mentioned before, it's challenging fiscal
12 times, and we're trying to figure out how to
13 make -- move forward and be a little bit more
14 efficient. I hear you about the cystic
15 fibrosis issue. And figure out other ways to
16 make sure we're able to provide some of the
17 services for those individuals that --
18 SENATOR RIVERA: And this is on top of
19 the fact that this is the stuff that is for
20 2021, right, the stuff that you did -- this
21 is stuff that you're proposing for now.
22 And also we talked about earlier about
23 the fees for -- children's camp permit fee,
24 asbestos safety program certificate,

1 Certificate of Need fees, which give us
2 $680,700. It just seems to me like this is
3 all a pittance in the big scheme of things,
4 and that we should be looking elsewhere,
5 particularly on taxing the wealthy. But
6 we're going to have a whole conversation
7 about that another time.
8 For you folks, I've got two more.
9 First, the -- as it relates to both of those
10 things, so if you are asking us to say
11 that -- there were a bunch of people that
12 brought up -- there was the Maximus contracts
13 that were brought up. The fact that there
14 was a very clear statement that said that
15 there were no cuts, when there obviously are.
16 The MRT conversation that we've had over and
17 over again, which says -- you provide no
18 details about anything. And then you also,
19 as it relates to this -- what we're trying to
20 figure out is how it is driving the cost,
21 right? I will admit to you that I am not as
22 smart as many of the folks that we have in
23 our central staff. And our central staff
24 have been talking to your central staff and

1 asking very specific, pointed questions so we
2 can have a better understanding of what
3 exactly is driving costs. Tell us where it
4 is, right, and the exact information -- you
5 seem to have the numbers, but you can't tell
6 us where they come from. And they're asking
7 you better questions than ever I could, and
8 you're not giving it to them.
9 So all of this, this is what I want to
10 get to. And I want to make sure this is
11 very, very clear. Whether it's on the MRT,
12 whether it's on the Maximus contract, whether
13 it's on the suggestion that there are no cuts
14 when there obviously are -- what you're
15 asking us to do as a Legislature is to trust
16 you. Folks, this don't build trust. I will
17 only speak for myself in this moment, but I
18 figure many of my colleagues can agree: We
19 don't trust you. You gotta build that. This
20 ain't helping.
21 And the last thing that I'll say, in
22 the last 50 seconds, is one other thing that
23 just -- as if we didn't have enough stuff to
24 deal with, and this is something that is

1 bigger, the public charge rule that was just
2 implemented, right, the Supreme Court
3 decision just a couple of days ago -- it was
4 literally a day ago. We've really got to get
5 into that. We've really got to get into
6 that, because that could have a potential
7 impact of $7 billion, according to some
8 analyses. And if we're already in this mess
9 and you're not being honest with us -- we've
10 got to fix this together. You've got to
11 build trust to do that. This don't do it.
12 The hours that we've spent here does not do
13 it. And you know I like you folks. But I'm
14 not going to be -- I'm not going to sit here
15 and not say that all this fighting that we're
16 doing is because we know the impact that it
17 has in our communities back home.
18 We've got to fix this together, we've
19 got to do it by building trust. We don't
20 trust you. You've got to make us trust you.
21 This does not help.
22 Thank you, Madam Chairwoman.
23 CHAIRWOMAN WEINSTEIN: Thank you. We
24 go to Assemblywoman Solages.

1 ASSEMBLYWOMAN SOLAGES: Hi, good
2 afternoon. Thank you, Chairwoman.
3 I'm not going to belabor the point
4 about the MRT or the MRT II, because as you
5 know, New Yorkers pay some of the highest
6 property taxes. So any cost shift is really
7 going to affect our bread-and-butter
8 families, and any cuts is going to affect our
9 most vulnerable. So I'm going to leave that
10 to you.
11 So I just want to move on to birth
12 workers. Birth workers. So the other day,
13 or last year, New York State launched a pilot
14 for doula care. And it was very exciting. I
15 know in Erie County the pilot has been
16 initiated and it's currently -- the findings
17 are happening.
18 However, in Kings County, I hear that
19 the pilot hasn't even gotten off the ground.
20 So can you give us a status update regarding
21 the doula pilot?
22 COMMISSIONER ZUCKER: I'll get you the
23 details on where it is in Kings County. I
24 know that this was a discussion, it's just

1 slipping my mind on where we are on that. I
2 know that that was -- that it has started in
3 other parts of the state.
4 ASSEMBLYWOMAN SOLAGES: Yes, many of
5 the doulas are upset because you know,
6 obviously, they cannot work for free. And I
7 know the state was proposing a fee that
8 wasn't realistic to the amount of visits that
9 are needed.
10 So you made a mention that you're
11 committed to, you know, reducing mortality
12 and morbidity --
13 COMMISSIONER ZUCKER: Maternal
14 mortality.
15 ASSEMBLYWOMAN SOLAGES: And so I hope
16 that there can come accord, because this
17 pilot was announced, you know, probably a
18 year or two ago, and we're still sitting here
19 not having a pilot in Kings County.
20 COMMISSIONER ZUCKER: Let me look into
21 that.
22 ASSEMBLYWOMAN SOLAGES: Thank you.
23 COMMISSIONER ZUCKER: My data is not
24 up to -- I know this from a couple of months

1 ago, but I'd rather answer you with the most
2 recent data.
3 ASSEMBLYWOMAN SOLAGES: I look forward
4 to it.
5 So I want to just go back to the
6 Commodity Supplemental Food Program. As you
7 know, there was a cut and many seniors on
8 Long Island were left with, you know, not
9 having access to food. And we know that
10 there's a high risk between food insecurity
11 and what's going on with seniors.
12 So can you give us simply a status
13 update about what's going to happen after
14 this emergency stopgap measure is done?
15 COMMISSIONER ZUCKER: So we are
16 looking at other ways to provide funding for
17 that -- and some emergency contracts,
18 transition those seniors to other food access
19 programs. So we recognize that. And
20 Senator Kaminsky raised that with me, or with
21 all of us, a little while ago about that
22 whole issue, about the access to food for
23 seniors.
24 So we will figure that out. And we're

1 working on a longer-term plan because it's
2 not -- we recognize that just a stopgap
3 measure won't solve the problem.
4 ASSEMBLYWOMAN SOLAGES: Correct. Is
5 there any moneys that were put in the budget
6 to help alleviate this issue forthcoming?
7 Because the contract is not going to be
8 renewed, or an RFP is not going to go out
9 until four years from now. So what's going
10 to happen in between now and --
11 COMMISSIONER ZUCKER: We'll look for
12 what kind of emergency contract we could put
13 into place. But let me -- let me figure out
14 a little bit -- let me get back to you about
15 the specifics of how we can make sure there
16 isn't a gap there for those individuals.
17 ASSEMBLYWOMAN SOLAGES: Okay. And
18 what is the Department of Health doing to
19 prevent such -- I know that there was an
20 issue with one of the contractors not
21 facilitating or opting in, and no one from
22 Long Island actually went and bid for the
23 contract. And so Long Island was left not
24 having a service provider.

1 So what is the Department of Health
2 doing to prevent that from ever happening
3 again?
4 COMMISSIONER ZUCKER: Right. So
5 that's exactly correct, that someone did not
6 bid. And we were not in the place to be able
7 to say to them, Well, you didn't bid, because
8 that's -- it's a competitive procurement
9 process, so we couldn't say anything until we
10 issued the contract. So that put them in a
11 difficult situation, obviously.
12 So I think the lesson learned from
13 there is, going forward, to figure out is
14 there any way to make sure people are aware
15 that this is not so much a contract but that
16 there is a -- something put out for bid ahead
17 of time. And maybe the answer is -- and I
18 have to figure this out, whether to, you
19 know, go to the legislators and say this is
20 something that your community is -- has had
21 in the past, and is there a way to make sure
22 that you're aware that that program is coming
23 to an end.
24 I don't know if that's legally

1 allowed, so I have to figure out what's
2 legally allowed. But I recognize what you're
3 saying, is how do we make sure that it
4 doesn't happen again that there -- whether
5 it's in Long Island or elsewhere, that there
6 is a gap because something didn't get
7 processed at the right time.
8 ASSEMBLYWOMAN SOLAGES: Many seniors
9 on Long Island are relying on a solution.
10 COMMISSIONER ZUCKER: I know. I know.
11 ASSEMBLYWOMAN SOLAGES: And so we need
12 to come to the table and figure this out.
13 COMMISSIONER ZUCKER: I hear you. I
14 hear you.
15 ASSEMBLYWOMAN SOLAGES: People can't
16 go hungry in New York State.
17 COMMISSIONER ZUCKER: I hear you. And
18 they won't.
19 ASSEMBLYWOMAN SOLAGES: Thank you.
20 CHAIRWOMAN WEINSTEIN: Thank you.
21 Senate?
22 CHAIRWOMAN KRUEGER: I think we're
23 done. Keep going.
24 CHAIRWOMAN WEINSTEIN: Assemblyman

1 Salka.

2 ASSEMBLYMAN SALKA: First of all,

3 thank you, Doctor. Thank you, Director.

4 Your testimony has been very informative.

5 And having spent 32 years on both the

6 clinical and the managing side of medicine,

7 I'm sure we can agree it's changed quite a

8 bit. We have the miracle of modern medicine,

9 but that miracle comes with very, very high

10 costs. Nonetheless, if it's saving lives,

11 then that's worth every penny of it.

12 I just want to reiterate what some of

13 my colleagues have said about emergency

14 medical services and just the stress that in

15 upstate New York emergency medical services

16 right now are at a critical junction. A lot

17 of them are looking at maybe a year at most

18 of being able to provide services. And in

19 rural areas, it's very, very important,

20 obviously, just like any other urban area.

21 Also, we're looking at a critical

22 shortage of providers in upstate New York. I

23 was the director of a cardiac lab, and

24 believe me, we had a near impossible time

1 trying to find a cardiologist. So again, I
2 would hope that you give that the highest of
3 priorities.
4 One question -- I see that we're doing
5 a bit of a root cause analysis here. One
6 question I have is that when the Affordable
7 Care Act was incorporated, was initiated, it
8 came with the promise of certain subsidies
9 because we knew that the states were going to
10 increase their numbers -- sometimes almost
11 near exponentially -- quite a bit. And I'm
12 sure that happened in New York.
13 Have those subsidies kept up with the
14 increased enrollment? And if they haven't,
15 shouldn't we be lobbying our federal
16 representatives too to be able to take care
17 of any shortfalls in funding that we should
18 be getting for Medicaid subsidies in New York
19 State?
20 MEDICAID DIRECTOR FRESCATORE: Yeah,
21 I'm happy to try to address that.
22 So the Affordable Care Act did in fact
23 include higher levels of federal match
24 subsidies, in effect, for certain

1 individuals. New York had been one of, you
2 know, five or so states that had gone ahead
3 and extended, through state law, coverage to
4 childless adults. And so the expansion group
5 here in New York wasn't large compared to
6 some other states, and we continue to get
7 nearly 100 percent federal match for the new
8 enrollment, the expansion group, which is
9 about 220,000 people. It's relatively small
10 in the context of the 6 million people.
11 You know, I think that, to answer your
12 question, yes. I mean, given we've made
13 tremendous progress here in insuring people,
14 and we think insurance is the gateway into
15 being able to access care, and access to care
16 lets us build providers and communities
17 throughout the state. The upstate counties
18 have had tremendous growth in coverage rates,
19 I mean, quite impressive, and we commend
20 them, particularly the community groups that
21 get out there and help spread the word about
22 the availability of the coverage.
23 But, you know, I think given the
24 opportunity, there are some parts of the

1 Affordable Care Act that we clearly would
2 like to see changed federally. The match
3 rates are one of them. There are a couple of
4 other places where we think that the coverage
5 could be structured if we were given the
6 chance to make that case, so that there was
7 less out-of-pocket costs for people.
8 So we always look for those
9 opportunities. We've been very -- you know,
10 as Senator Rivera mentioned, the public
11 charge rule, I think that, you know, that
12 these are individuals who are entitled under
13 federal law for coverage. And that certainly
14 it's frightening to people to come forward
15 and get coverage if you think that your path
16 or your family's path to citizenship could be
17 in jeopardy by doing that. That's one of the
18 reasons we -- the Supreme Court decision, one
19 of the reasons we extended our open
20 enrollment period by a week.
21 So yes, I mean I think that given the
22 opportunity, we would look for more Medicaid
23 support. Unfortunately, what we're seeing,
24 perhaps as soon as tomorrow, is the ability

1 for states to go in to the federal government
2 under a waiver and ask for block grants, so
3 that they can cover fewer people or give, you
4 know, people fewer benefits. Which just puts
5 additional costs on the healthcare delivery
6 system, in our view.
7 ASSEMBLYMAN SALKA: Thank you. Thank
8 you for your answer.
9 MEDICAID DIRECTOR FRESCATORE: Long
10 answer, I apologize.
11 ASSEMBLYMAN SALKA: Oh, that's fine.
12 That's fine. It was a good answer, thank
13 you.
14 CHAIRWOMAN KRUEGER: Okay, another
15 Assemblymember.
16 CHAIRWOMAN WEINSTEIN: Yes. We go to
17 Assemblyman Abinanti.
18 ASSEMBLYMAN ABINANTI: Thank you both
19 for joining us today. The ordeal is almost
20 over, but not quite yet.
21 I think the reality of the budget does
22 not match the rhetoric that we've heard that
23 New York actually cares about its citizens.
24 I think what we have before us is in general

1 an overly complicated proposal which is not
2 serious, but is designed to divert attention
3 from the fact that the entire approach is to
4 cut state costs, no matter what the cost to
5 people, and to shift the blame to somebody
6 else -- to an MRT, to our counties, to the
7 outside contractors.
8 You keep talking about we're looking
9 for efficiencies and savings. You've had
10 10 years to come up with efficiencies and
11 savings. This administration has been in
12 charge for 10 years. And we're going to
13 solve all these problems, which you see as
14 challenges, in the space of a few weeks with
15 another group of people coming together.
16 Number one, on the MRT. You've always
17 said it's a success. To the people who use
18 New York State services, it's a failure.
19 They're not getting the services they need.
20 I speak particularly for the people with
21 developmental disabilities. They can't find
22 services. They're not there. The help they
23 get is inadequate.
24 So I'm hopeful that when you put

1 together this MRT II, you put on that a
2 consumer to match every industry group that
3 sits on that board -- some consumer advocacy
4 group that's going to speak for those who
5 seek the services and use the services, not
6 just those who deliver the services. And I'd
7 like to see them appointed by the Speaker and
8 the Majority Leader, not by the Governor's
9 office.
10 Secondly, you talk about involving the
11 counties again. Medicaid is a state
12 responsibility, not a county responsibility.
13 We're the only state in the country that asks
14 our counties to contribute as much as they
15 do. I believe they have a role in
16 contributing some money, but they do not have
17 the power to determine what services people
18 get.
19 Let's talk about people with special
20 needs. It's OPWDD that determines how many
21 hours somebody gets, not the County of
22 Westchester or any one of our counties.
23 So what we're doing is asking the
24 counties to share the blame for knocking

1 people off and not getting services, so that
2 the state can say they care about people.
3 And if the counties actually do have to pick
4 up more of the cost, you're destroying their
5 budgets. They're going to have to cut back
6 on roads, they're going to have to cut back
7 on all of their other services, because they
8 want to stay within the property tax cap.
9 Because there are disastrous results if they
10 don't.
11 Now, you talk about they could look to
12 the assets. Well, we already impoverish
13 people to get Medicaid. If you're a person
14 with a disability, you have to meet a
15 spend-down: $859 for a person in Westchester
16 County. You can't live on $859. You can't
17 even be in an apartment. And so by having
18 such a low level for spend-down -- and you're
19 suggesting that the counties look for more
20 assets, as if these are rich people who are
21 hiding their assets just to get services.
22 It's not going to work. You're just shifting
23 the blame to the counties and creating more
24 problems.

1 Now let's talk about the deficit for a
2 moment, point three. This is a self-created
3 crisis. As I'm understanding it, you shifted
4 $2 billion from last year's budget into this
5 year's budget. You did nothing about the
6 spending last year, so you're going to have
7 another $2 billion deficit because you're
8 spending the way you were spending last time.
9 And you're including more every year
10 in your Medicaid column that used to be in
11 other columns. This year you've shifted a
12 billion dollars for OPWDD from the spending
13 column there to the Medicaid spending column.
14 You've been paying for it through Medicaid
15 all along, so I'm not talking about where the
16 monies are coming from in. I'm talking about
17 where you're showing them in the budget. The
18 whole thing is a big charade. So that's a
19 billion dollars more that you're going to be,
20 quote, spending on Medicaid that used to be
21 in a different column somewhere else. So you
22 bump up against the 3 percent level because
23 you don't want to spend the money to help the
24 people who need the help.

1 You rolled over the $2 billion --
2 there was no shortage of cash; you could have
3 paid for it. You rolled it over because you
4 didn't want to exceed the arbitrary 3 percent
5 cap. You've inflated the over -- the
6 spending, as I just noted, from basically
7 just budgetary acrobatics, to make the
8 problem look bigger, and then you're a victim
9 of your own success.
10 You have privatized Medicaid. When
11 you privatize it, you've asked the private
12 sector and the not-for-profit sector to go
13 out and pick up people and put them into the
14 plans. Well, they've been successful at
15 doing that.
16 I'd like to hear from you how much it
17 costs for administration versus what it used
18 to cost for administration, and how much is
19 actually going to direct services for people
20 versus what it used to be. You're now paying
21 all of these managed-care plans for their
22 administration. They get a per capita or
23 whatever. They've got to go out and sign
24 people up.

1 But the people are not getting the
2 services. Okay, they may be part of the
3 plans, but they're not getting the services.
4 And I think this is a faulty strategy to
5 privatize it. And we've had people talk
6 about other contracts, the Maximus,
7 et cetera.
8 And lastly, I just want to -- and this
9 is maybe where I'll ask you the question.
10 Where did you come up with 3 percent? You're
11 using the 3 percent cap and saying there's a
12 deficit because we can't keep our spending
13 within the 3 percent, even though you admit
14 that there's been a huge increase in the
15 needy population who need the services.
16 So why are we sticking to a 3 percent
17 cap? Where did that come from, where did
18 that become the magic number? It's not a
19 shortage of money and cash to pay for
20 services. It's just that you have said we're
21 going to stay at a 3 percent, if we're over
22 3 percent we've got a deficit. Where did you
23 come up with the 3 percent?
24 And the second question is, are you

1 still pushing managed care for people with
2 developmental disabilities? Last year you
3 had money in the budget to at least help the
4 transition. There's no money in the budget
5 for the transition. Did you spend the
6 $5 million from last year? And what are you
7 going to do this year?
8 So it's two questions, really, the
9 basis for the evaluation of 3 percent and the
10 managed care for people with developmental
11 disabilities.
12 CHAIRWOMAN WEINSTEIN: So maybe you
13 can answer those offline -- or unless you
14 have a quick response.
15 MEDICAID DIRECTOR FRESCATORE: If I
16 could, Assemblyman, the basis for the
17 3 percent is in state law, and 3 percent is
18 the math on the rolling 10-year average of
19 the Consumer Price Index.
20 ASSEMBLYMAN ABINANTI: Oh, I'm aware
21 of that. But it was put in there because the
22 administration wanted it.
23 CHAIRWOMAN WEINSTEIN: Assemblyman,
24 that's -- Assemblyman, the time has expired.

1 Thank you.
2 We'll move on to Assemblyman
3 Palmesano.
4 ASSEMBLYMAN PALMESANO: Yes, thank
5 you. I have a couple of questions.
6 Before I do, I notice there's some
7 emergency service workers in the audience,
8 and I just want to say -- I'm sure I speak
9 for everyone -- thank you for what you do
10 each and every day to keep our communities
11 safe and saving lives. And given the impact
12 that the budgets -- Medicaid has on them,
13 they should probably have a seat at the table
14 as well.
15 But I wanted to go back to the
16 question relative to the expansion of the
17 Affordable Care Act or Obamacare, however you
18 want to refer to it. I think it happened
19 around 2014. And the big -- everyone praised
20 it, everyone said, Well, because the feds are
21 going to pay for it, they're going to pay a
22 hundred percent at the beginning, and then
23 it's going down to 90 percent. Billions of
24 dollars to expand.

1 And I guess it's around 90 percent
2 now, but nothing keeps it there permanently.
3 They can drop it at any time given their
4 fiscal situation, which would create a big
5 shift to us.
6 And I want to ask these questions
7 first to get them out before I forfeit my
8 time.
9 So what's to stop that, if that is
10 dropped? And that's more that's going to be
11 put back onto the state and also going to be
12 shifted. So everyone praised this, but
13 there's fiscal implications to this as well.
14 Another thing that really aggravates
15 me about this budget and the Governor's
16 proposals, I think -- can you guys, can you
17 both list specifically what counties can do
18 to cut Medicaid costs and growth? Because we
19 already determined, we know that eligibility
20 expansion, those guidelines are established
21 by the federal government and the state
22 government, not the counties. The counties
23 just follow the requirements that are given
24 to them and pay the bill.

1 If there's program expansion, like the
2 Affordable Care Act, expansion of that, that
3 was determined by the state, not by the
4 counties. The 30-plus optional Medicaid
5 programs that we have, those were determined
6 by the state, not the counties. They didn't
7 opt into that. They just are given a bill to
8 say "Pay it." And the Governor says and the
9 Budget Director says counties have to have
10 skin in the game. They do have skin in the
11 game. They pay $8 billion now. So they
12 already have skin in the game.
13 So where are they supposed to cut?
14 Are they supposed to cut services to the
15 seniors and the disabled, for long term care
16 and nursing home care? Are they just
17 supposed to put those people back out on the
18 street? Where are they supposed to cut and
19 what can they do?
20 And listen, quite frankly, if the
21 Governor wants to say locals need to pay
22 more, the property tax payers need to pay
23 more, then he should just say it. But he's
24 already got it planned in his budget to the

1 tune of $150 million a year. But it's
2 completely disingenuous, an insult and false
3 for him to say counties have absolutely any
4 say or control on the cost or growth in the
5 Medicaid program. He knows that, you know
6 that.
7 And quite frankly, when you talk about
8 staying within the property tax cap, how are
9 they supposed to stay within the property tax
10 cap when you have this cost shift of Medicaid
11 that's going to happen, not to mention other
12 cost shifts that are affecting county budgets
13 with the so-called criminal justice reform,
14 bail reform, discovery requirements that are
15 shifting incredible costs to those counties?
16 So how are they supposed to stay under
17 the property tax cap with the challenges
18 they're facing now? And then on top of it,
19 this Medicaid shift, that's going to be more
20 than the property tax. They can't do it.
21 It's wrong.
22 And I just -- so those are the points
23 I want you to address. One, about ACA, if
24 there's changes in the reimbursement, we're

1 on the hook for that. That's going to get
2 shifted -- if that gets shifted as well,
3 that's going to drive up costs. There's no
4 guarantee with the federal fiscal situation.
5 And two, what specific programs can
6 the counties do, because they have no control
7 over eligibility, they have no control over
8 program expansion, they just implement what's
9 given to them. And now the Governor and you
10 are saying "You need to pay more," to the
11 tune of at least $150 million which he's
12 already budgeted for. It's disingenuous and
13 wrong.
14 MEDICAID DIRECTOR FRESCATORE: So let
15 me start with your question about the federal
16 support for Medicaid.
17 So, you know, we look at the different
18 sources, different types and categories of
19 covered individuals in Medicaid: 4.9 million
20 of the 6.2 million are the traditional
21 Medicaid program. Those are in the rules
22 where the match rates for New York are about
23 50 percent -- 50 percent federal money, the
24 other 50 percent non-federal share, as we

1 call it. So some combination of state and
2 local.
3 The expansion that the state did
4 before the Affordable Care Act is about
5 1.2 million people. The federal government
6 pays 75 percent of the cost of those
7 individuals. With the Medicaid expansion,
8 that's specifically in your child -- adults
9 without children, between 100 and 138 percent
10 of the federal poverty level, 220,000 people,
11 the federal government pays 100 percent.
12 That -- those are in law, those are in
13 federal law. If your question is could
14 Congress change that, I suppose that is
15 possible. But this is based on what is
16 currently in federal law, and the law would
17 need, you know, to be changed. So that's
18 kind of how the shares break out. It's
19 depending on people.
20 To get to your second question, I
21 think we've talked about this, you know,
22 several times throughout the course of the
23 morning here, and early afternoon. Local
24 districts play some important roles in

1 day-to-day administration of the program. We
2 believe that -- I believe that they are
3 closest on the ground, they see what happens
4 in their local districts, and that they can
5 partner with us in finding ways to reduce and
6 bring -- you know, to rein in the growth in
7 costs. And I can tell you I talk to
8 districts from time to time who say, Jeez,
9 you know, what if we did this.
10 The two places where the local
11 districts have a role, again, they process
12 47 percent of the total Medicaid
13 applications. So 47 percent of 6.2 million
14 have their determinations made by the local
15 district, the county, generally, in which
16 they reside. And they play a role, as I
17 mentioned before, in approval of certain
18 services; in particular, long-term-care
19 services, personal care, consumer-directed
20 care, and some other services that have costs
21 on the fee-for-service side of billions of
22 dollars a month.
23 And so we want to partner with them,
24 we want them to come to the table in a way to

1 work with us and all of you to address the
2 escalation in costs so this program is
3 sustainable for everyone.
4 ASSEMBLYMAN PALMESANO: So partner
5 with them, don't punish them.
6 CHAIRWOMAN WEINSTEIN: We go now to
7 our chair of Health for his second round,
8 Assemblyman Gottfried.
9 ASSEMBLYMAN GOTTFRIED: Okay, I have
10 a few questions which are I think short and
11 can hopefully be answered pretty briefly.
12 One is to clarify. Is it within the
13 jurisdiction of the MRT II, if it chooses to,
14 to consider and propose changing the cap, the
15 global cap, and what gets treated under the
16 cap and not? And secondly, closely related
17 to that, can it consider tax proposals?
18 COMMISSIONER ZUCKER: I can't answer
19 that question right now until we sit down
20 with the MRT II team. But I will get back to
21 you about those two.
22 Donna?
23 MEDICAID DIRECTOR FRESCATORE: Yeah, I
24 think, you know, I -- I think I might add

1 that we won't know for certain until this --
2 till more has started about the process.
3 But while I -- again, we look at the
4 cap as a tool for us all to measure, I think
5 there is openness for --
6 ASSEMBLYMAN GOTTFRIED: Yeah, I
7 understand the merits or demerits of the cap.
8 MEDICAID DIRECTOR FRESCATORE: There's
9 openness of the metric that's used. It would
10 be -- it's an open decision --
11 ASSEMBLYMAN GOTTFRIED: We're trying
12 to keep the answers brief. I wasn't asking
13 whether the cap is a good idea. I was asking
14 whether the MRT II will be barred from
15 thinking, from proposing things about
16 changing the cap. And the answer is you
17 don't know yet. Okay.
18 The Assembly has been asking for
19 county-by-county local share spending
20 numbers. I'm sure you have that data. Can
21 you send it to me and to Ways and Means by
22 tomorrow?
23 MEDICAID DIRECTOR FRESCATORE: I will
24 confirm whether we can send it by tomorrow or

1 not. The --
2 ASSEMBLYMAN GOTTFRIED: And could you
3 speak into the microphone?
4 MEDICAID DIRECTOR FRESCATORE: Yeah,
5 we will confirm whether we can send that to
6 you by tomorrow or not.
7 But the April through December report
8 has some information that's county by county
9 in it. I think that might be of help. But
10 we'll get back to you later today or in the
11 morning.
12 ASSEMBLYMAN GOTTFRIED: Okay. Because
13 apparently what we've been getting is the
14 increase in the -- in what the state is
15 picking up of what used to be paid by each
16 county. But what we want to know is what
17 each county is currently spending. And I'm
18 quite certain you have that. And I'm quite
19 certain there is a DOH employee who could, at
20 the push of a button, send me that table.
21 So I'd appreciate it if they would --
22 if you would find that employee and tell them
23 to do that.
24 Similarly, the monthly global cap data

1 that has been asked about. I'm sure that in
2 an enterprise the size of DOH there is
3 somebody who can, on their computer, see that
4 number daily. And the fact that it's not
5 being generated monthly may be why
6 Mr. Mujica, in a New York Times story about
7 how surprised everyone was about the spending
8 going so wildly over the global cap, why
9 Mr. Mujica said that he didn't know that that
10 was happening. Which was, I think, kind of
11 striking to a lot of people.
12 So my question is, could you resume
13 generating that data on a monthly basis and
14 send it to me and Mr. Mujica?
15 MEDICAID DIRECTOR FRESCATORE: It's
16 our intention to generate reports on a
17 monthly basis.
18 ASSEMBLYMAN GOTTFRIED: Excuse me?
19 MEDICAID DIRECTOR FRESCATORE: It is
20 our -- it's our intent going forward to
21 generate those reports on a monthly basis.
22 ASSEMBLYMAN GOTTFRIED: And to send
23 them to us like right away, as they're
24 generated.

1 MEDICAID DIRECTOR FRESCATORE: Yeah,
2 they're public reports, so I think as soon as
3 they're generated and we do our quality
4 assurance, they're available publicly.
5 ASSEMBLYMAN GOTTFRIED: Well, okay.
6 Unfortunately, for the Health Department to
7 say something is public data doesn't mean I
8 can see it, given the rate at which the
9 department responds to FOIL requests.
10 MEDICAID DIRECTOR FRESCATORE: We --
11 we -- I wasn't clear. We post them on the
12 website.
13 ASSEMBLYMAN GOTTFRIED: The monthly
14 global cap data?
15 MEDICAID DIRECTOR FRESCATORE: The
16 monthly global cap reports.
17 ASSEMBLYMAN GOTTFRIED: Are posted
18 monthly?
19 MEDICAID DIRECTOR FRESCATORE: Well,
20 we had -- as we talked about earlier, there
21 was a period of time where they were not
22 available. But our intent going forward is
23 to produce these reports monthly, and they
24 are posted on the DOH website. We can get

1 that site, you know, for everybody if that's
2 helpful, the link.
3 ASSEMBLYMAN GOTTFRIED: You mean they
4 will be posted. And with how much lag after
5 the month involved?
6 MEDICAID DIRECTOR FRESCATORE: You
7 know, we need to let all the data for the
8 month complete, and -- so I don't know. We
9 can -- I can give you a best estimate of
10 that. But I need to talk to our analysts who
11 work with those data sets all the time to
12 give you an accurate expectation.
13 ASSEMBLYMAN GOTTFRIED: Okay. Earlier
14 you were saying what -- on the question of
15 what role the counties play in determining
16 eligibility for care, and you talked about
17 the local social services districts
18 determining some huge amount of home care
19 eligibility.
20 As I understand it, the localities
21 make that determination for fee-for-service,
22 which is to say less than 120 days home care,
23 but that 90 percent, roughly, of home care is
24 long-term home care, over 120 days, and

1 that's not determined by the county, it's
2 determined by some combination of Maximus and
3 managed long term care plans. Do I have that
4 right?
5 MEDICAID DIRECTOR FRESCATORE: Well,
6 partially. But there's also people who are
7 in -- who receive long-term-care services who
8 are not required to join a managed-long-term-
9 care plan. So individuals that are not
10 dually eligible are not required, so those
11 individuals would remain in fee-for-service,
12 as well as some other individuals that are
13 exempt from having to join a managed-care
14 plan, and their care plan would continue to
15 be developed and their six-month reassessment
16 done by the local district.
17 So the numbers I gave you are for
18 people in fee-for-service.
19 ASSEMBLYMAN GOTTFRIED: But about
20 90 percent of home care, as I understand it,
21 is in fact required by law to be done through
22 a managed long term care plan.
23 MEDICAID DIRECTOR FRESCATORE: What's
24 required by law is who has to join a managed

1 care plan, not how much home care has to be
2 in the plan.
3 And when we look at the data, what we
4 see is that state -- that statewide, there
5 are 907,000 -- that's the number I cited
6 before -- individuals who are in
7 fee-for-service who receive either personal
8 care or consumer-directed care where their
9 care planning would be done by the local
10 district.
11 It's about 34 percent of people who
12 receive those services statewide, with the
13 remaining 66 percent getting those services
14 and the care planning done by their managed
15 care organization.
16 ASSEMBLYMAN GOTTFRIED: Okay, I --
17 CHAIRWOMAN WEINSTEIN: Thank you.
18 ASSEMBLYMAN GOTTFRIED: I assume you
19 have -- just I assume you have a document
20 that says how much money is spent on
21 long-term care through MLTCs and how much is
22 spent through fee-for-service. I'd like to
23 see that data.
24 MEDICAID DIRECTOR FRESCATORE: Okay,

1 let me -- I don't have that with me. Let me
2 see if we can't get that to you.
3 CHAIRWOMAN WEINSTEIN: Thank you.
4 We'll go to the ranker on Health, Mr. Byrne.
5 ASSEMBLYMAN BYRNE: Thank you. I'm
6 going to try to be very watchful of that
7 clock, because we have a shrinking amount of
8 time. And I'm going to follow up on some of
9 the questions that I had before.
10 The opioid tax that was implemented
11 last session, where is that money going? And
12 is it going to folks who are suffering from
13 addiction?
14 COMMISSIONER ZUCKER: Does it go back
15 to helping those -- it's not --
16 ASSEMBLYMAN BYRNE: Dedicated funding,
17 I think I kind of -- it's not dedicated to
18 anything individual, correct?
19 COMMISSIONER ZUCKER: I don't think
20 it's specifically dedicated. But it's going
21 to tackle this whole issue in multiple
22 different sectors.
23 ASSEMBLYMAN BYRNE: I know -- speaking
24 for myself, and I think many of my

1 colleagues, I'd like to make sure that those
2 dollars are being used to help those who are
3 suffering from addiction.
4 Second question, with -- my colleague
5 spoke about the 3 percent surcharge. Are
6 those dollars dedicated, or is that just
7 going to be sucked up into the Albany vacuum?
8 COMMISSIONER ZUCKER: Which, sir?
9 ASSEMBLYMAN BYRNE: The 3 percent
10 surcharge on, I'm sorry, the Certificate of
11 Need facilities that we were talking about
12 earlier when we started this hearing, several
13 hours back.
14 COMMISSIONER ZUCKER: Well, that's --
15 we were mentioning that it's administrative
16 and this has become very challenging, the
17 number of Certificate of Needs that are out
18 there. And if you're asking where it's going
19 to go, it's going to go to help making the
20 system even more efficient and more timely.
21 ASSEMBLYMAN BYRNE: So -- okay, so not
22 a specific dedication there.
23 Now, with -- I mentioned it before, a
24 bill that the Governor vetoed, Assembly Bill

1 7246, that removed prior authorization for
2 MAT in Medicaid. He vetoed that, but he
3 signed a different bill that wasn't specific
4 to Medicaid. It just seems I'm getting --
5 we're getting two kind of different messages
6 here. And this might be something to be
7 brought up with OASAS at a different public
8 hearing.
9 But it just seems to me that if we're
10 going to have revenue from the opioid tax,
11 that might be a place for revenue to go, to
12 help support those services, if it's
13 something that the administration wants to
14 make a priority.
15 So I just wanted to -- if you have a
16 response on the veto, that would be helpful.
17 But also I just wanted to plant that seed as
18 one of many options, I think, to try to help
19 expand that need.
20 COMMISSIONER ZUCKER: Well, the one
21 thing I will say about that is that we wanted
22 to look at that closer on the Medicaid front,
23 you know. And there are other components to
24 that that we're going to try to address

1 regarding the MAT from the Medicaid side.
2 ASSEMBLYMAN BYRNE: Now, before I run
3 out of time I want to follow up on a question
4 that my colleague Mr. Garbarino asked about
5 tobacco shops, an exemption for specialty
6 shops, like a cigar shop, tobacco shops.
7 You answered it specifically talking
8 about the marketing with flavors, but the
9 question was really about the language in the
10 budget from the Executive's proposal about
11 marketing in storefronts, signs, things like
12 that. It's not necessarily about flavors of
13 tobacco products.
14 So are tobacco shops, specialty shops,
15 are they going to be exempt from some of
16 those new requirements so they'll be able to
17 be still market within their stores? I mean,
18 it's pretty clear what they are, they're a
19 tobacco shop, and there's no other reason to
20 go there.
21 COMMISSIONER ZUCKER: So the -- it
22 will restrict the delivery of the e-liquid
23 products to New York State to -- only to
24 New York State-licensed vaping shops.

1 ASSEMBLYMAN BYRNE: That's the vape
2 issue.
3 COMMISSIONER ZUCKER: Right.
4 ASSEMBLYMAN BYRNE: But there's other
5 marketing about -- I thought there was
6 inclusion of greater restrictions on the
7 marketing of tobacco products as well, not
8 just flavors. Signage in storefronts, things
9 like that.
10 COMMISSIONER ZUCKER: Right. So, I
11 mean, the issue will restrict all
12 vaping-related ads targeted to youth. And
13 you're asking whether that will be --
14 ASSEMBLYMAN BYRNE: And not just vape,
15 but tobacco too.
16 COMMISSIONER ZUCKER: Of course, yes.
17 ASSEMBLYMAN BYRNE: Traditional
18 tobacco.
19 COMMISSIONER ZUCKER: We've made a
20 strong effort on the issues of tobacco.
21 We've been very successful on that front in
22 driving tobacco numbers down in the State of
23 New York.
24 CHAIRWOMAN WEINSTEIN: Thank you.

1 And I believe the final questioner
2 will be Assemblyman Ra.
3 ASSEMBLYMAN RA: Thank you,
4 Commissioner. I just have a few issues I
5 want to get into. Obviously my colleagues
6 have covered a lot.
7 Just quickly, one that -- there was
8 talk last year about coverage of applied
9 behavior analysis for children with autism,
10 through Medicaid. I know there's been a bill
11 that's been around the Legislature for many
12 years. Is there any status on possibly
13 covering that administratively?
14 MEDICAID DIRECTOR FRESCATORE: The
15 implementation of that coverage is underway.
16 I don't have an effective date for you, but
17 it is underway.
18 ASSEMBLYMAN RA: Okay. Thank you. I
19 wanted to get into minimum wage as it relates
20 to Medicaid. The numbers in the financial
21 plan are, you know, higher, somewhat
22 significantly higher than what was identified
23 in last year's financial plan.
24 For financial year 2020 and 2021 we

1 have 1.5 billion, which is for 2020, which is
2 up from about 1.131 in last year's financial
3 plan, and 1.8 billion in 2021, which was, I
4 think, a little over 1.2 in last year's
5 financial plan.
6 So I'm just wondering, how are these
7 numbers being calculated? Are they just
8 wages? Do they include benefits? Do they
9 take into account, you know, the increases in
10 minimum wage potentially driving up -- you
11 know, higher wages?
12 MEDICAID DIRECTOR FRESCATORE: I think
13 they take into account all of those things.
14 So they have taken into account the change in
15 increase in minimum wage, which has now
16 reached $15 in New York City but continues to
17 escalate in other parts of the state.
18 And a large part of the increase that
19 you see from year to year is as the number of
20 hours of care increase. So as we see the
21 increase in use of long-term-care services
22 and enrollment in managed long term care
23 increase, the minimum wage costs increase as
24 well as more hours of care are provided.

1 ASSEMBLYMAN RA: And this data is
2 coming from providers to the department, is
3 that's how it's being calculated?
4 MEDICAID DIRECTOR FRESCATORE: I'm
5 sorry, could you say that again?
6 ASSEMBLYMAN RA: How is this data --
7 who's providing the numbers to make these
8 calculations?
9 MEDICAID DIRECTOR FRESCATORE: So for
10 individuals who receive their care through
11 fee-for-service, we actually have the claim
12 data projected forward.
13 Because the fee-for-service system
14 pays the claims, the data for the use of
15 services for individuals in managed-care
16 plans comes from managed-care reports and
17 encounter data that show the number of
18 services. Again, we're projecting forward
19 based on expected enrollment trends, which
20 are about 13 percent enrollment in managed
21 long term care year to year.
22 ASSEMBLYMAN RA: Okay. And is the
23 state reimbursing those providers for all the
24 minimum-wage-related costs or just the share

1 attributed for the Medicaid recipients?
2 MEDICAID DIRECTOR FRESCATORE: The --
3 it's -- the Medicaid reimbursement is for --
4 it's built into the hourly rate that Medicaid
5 reimburses for service rendered to a
6 Medicaid-covered patient.
7 ASSEMBLYMAN RA: Thank you.
8 CHAIRWOMAN KRUEGER: Thank you. We've
9 actually -- we haven't run out of questions
10 for you, but we've run out of time to allow
11 ourselves to ask more questions.
12 I think you have quite a long list of
13 answers you're going to get back to us on.
14 So four hours, not that bad. Thank you --
15 depending on how you count. Thank you very
16 much for being with us today.
17 And our next testifier will be Linda
18 Lacewell, superintendent, New York State
19 Department of Financial Services.
20 And a little leg stretching.
21 (Brief recess.)
22 CHAIRWOMAN KRUEGER: If people are
23 exiting, can you take your conversations out
24 of the room if you're exiting. Thank you.

1 And if you're staying -- look at you,
2 all quieted down perfectly. Thank you.
3 Superintendent, are you ready?
4 SUPERINTENDENT LACEWELL: I am. Thank
5 you, Senator.
6 CHAIRWOMAN KRUEGER: Thank you.
7 SUPERINTENDENT LACEWELL: Good
8 afternoon to the chairs, to Chairs Weinstein,
9 Krueger, Rivera, Gottfried, Breslin and
10 Cahill, and to the ranking members and to all
11 members, distinguished members, of the State
12 Senate and Assembly.
13 Thank you for inviting me to testify
14 today. I am Linda Lacewell. I am the
15 Superintendent of Financial Services at the
16 New York State Department of Financial
17 Services. We regulate many things, but as
18 relevant here, we regulate commercial health
19 insurance for the State of New York.
20 I am privileged to work for Governor
21 Cuomo and to have been confirmed by the State
22 Senate -- thank you -- in this task to serve
23 all New Yorkers in this role. I am happy to
24 provide an overview or highlight some of the

1 primary relevant healthcare reforms at issue
2 with respect to the Governor's Executive
3 Budget. And I will of course do my utmost to
4 answer your questions here today and take
5 back anything where you would like additional
6 information.
7 The mission of DFS is to protect
8 New York State consumers of financial
9 products and services, to oversee the safety
10 and soundness of our banking and insurance
11 industries and financial service industries,
12 and to safeguard the markets from fraud and
13 illegal activity and maintain their
14 integrity.
15 We regulate more than 1400 insurers of
16 all kinds, with assets of more than
17 $4.7 trillion and nearly 1500 additional
18 banking and other financial institutions with
19 assets of more than $2.6 trillion. So it's
20 an awesome responsibility. We do at DFS play
21 a significant role in the health insurance
22 market, and we carry out many of the
23 Governor's initiatives to protect and improve
24 the healthcare for all New Yorkers.

1 This year's budget builds on many of
2 the accomplishments from last year of the
3 Legislature and the Governor in the budget,
4 including of course the codification of vital
5 protections of the Affordable Care Act and
6 the Mental Health Parity Act and other such
7 matters.
8 A few of the reforms proposed in this
9 year's budget, as you know, include the
10 matter of prescription drugs. The Governor
11 is committed to fighting the high cost of
12 prescription drugs. The budget he has
13 proposed has a three-part plan; one, to cap
14 the cost of insulin for consumers with
15 respect to their out-of-pocket payments; two,
16 to give DFS the ability to oversee pricing of
17 prescription drugs where those prices spike;
18 and three, to facilitate with DOH a
19 feasibility study regarding the potential
20 importation of drugs from Canada.
21 On the issue of pharmacy benefit
22 managers, as you well know -- obviously this
23 is a recurring issue -- they are
24 intermediaries in the drug supply chain that

1 have amassed tremendous power and influence
2 with respect to the sale of federal
3 pharmaceuticals and the pricing, which of
4 course is a tremendous cost-driver with
5 respect to healthcare. Despite playing an
6 important role in highly regulated markets,
7 they have managed to be exempt from
8 regulation, and we have a resulting black box
9 with respect to their practices.
10 This year the Governor is proposing
11 legislation to bring PBMs under DFS
12 regulatory authority, to generate
13 transparency and light with respect to these
14 practices, to come up with a Code of Conduct,
15 and protect consumers from deceptive, unfair,
16 and abusive business practices.
17 With respect to surprise medical
18 bills, building on the prior work of the
19 Legislature and the Governor as we have led
20 the nation in protecting patients from
21 surprise medical bills, the Governor's budget
22 proposal would build on this success by
23 closing remaining loopholes that end up
24 passing on the cost to consumers, who should

1 be held harmless when there's a dispute
2 between the provider and the insurer;
3 requiring disclosure of fees that consumers
4 need to be aware of; and reducing the statute
5 of limitations on medical debt from six to
6 three years, which would bring us more in
7 line with a number of other states.
8 Additionally, the proposal would
9 provide medical cost transparency for
10 consumers of the pricing and quality of
11 medical services on a website that we would
12 work on in coordination with other agencies,
13 to bring that information in a
14 consumer-friendly manner to them.
15 As you know, the budget proposal
16 includes the vital issue of lifting the ban
17 on gestational surrogacy, which is important
18 to many people, and would create a
19 Surrogate's Bill of Rights to protect the
20 rights of the surrogate in that situation,
21 would ensure the right of the surrogate to
22 make her own healthcare decisions and have
23 access to comprehensive health insurance and
24 potentially life insurance.

1 Additionally, we have done vital work
2 together on expanding fertility services.
3 And as you know, the Governor's signed
4 legislation expanding IVF coverage for
5 large-group insurance plans and fertility
6 preservation services, irrespective of plan,
7 to millions of New Yorkers. We need to build
8 on that work and continue the work and expand
9 that realm.
10 On the issue of mental health parity
11 compliance, DFS and other agencies have
12 noted, as have many of you, that we have a
13 lot of work to do on mental health parity and
14 compliance, that the policies and procedures
15 in place currently are not adequate, and
16 therefore DFS, with DOH and other agencies,
17 will drill down on that and issue regulations
18 providing compliance, procedures and policies
19 that must be followed, to help ensure that
20 parity is a reality.
21 The financial services law passed in
22 2011 which created the Department of
23 Financial Services is a piece of legislation
24 designed to unify the oversight of banking,

1 insurance, and all financial products. It is
2 vitally important that we have comprehensive
3 standards to protect all consumers of all
4 products, whether it's a banking product, an
5 insurance product, or simply a financial
6 product that doesn't fall into any of these
7 categories. That was the intention of DFS
8 being created post-financial crisis.
9 Therefore, an important proposal the
10 Governor has put forward is a robust consumer
11 protection agenda that, among other things,
12 would bring much-needed oversight of the debt
13 collection industry; expand financial
14 inclusion and literacy across the state for
15 all communities, so all can participate in
16 the great financial products and services of
17 this state and not limit it just to some; to
18 reform the law to allow DFS to prevent and
19 stop and generate relief with respect to
20 abusive and deceptive practices, not just
21 those that are intentional.
22 And this is important because
23 unfortunately we lag behind many other states
24 and even the federal government with respect

1 to the legal standard imposed on us to get
2 relief for consumers.
3 I'm approaching my one-year
4 anniversary of beginning to work at DFS,
5 prior to, of course, my confirmation by the
6 Senate. I've been traveling the state, I've
7 been meeting with many of you, and also doing
8 some town halls to learn the concerns of your
9 constituents and our great New York
10 population. And one of the concerns that
11 keep me up at night -- and time after time,
12 what is brought to our attention -- are
13 practices that involve deception and unfair
14 practices that part New Yorkers from the
15 little money that many of them have as
16 they're balancing all the kitchen table
17 expenses that they have.
18 Homeowners in Brooklyn and Harlem who
19 are potentially going into foreclosure, and
20 they think they're getting relief, and
21 instead they are tricked into signing away
22 the deed to their home. Teachers on
23 Long Island paying thousands of dollars more
24 than they should for fees for their

1 retirement plan while a large insurer across
2 the board is reaping profits. A young
3 graduate in Buffalo paying more than they
4 should on student loans and then dealing with
5 those who promise relief and instead drive
6 them further into debt. Families in the
7 Bronx and elsewhere who are entitled to file
8 their tax return for free, under the law, and
9 instead are tricked into paying the fee that
10 they really don't have in order to comply
11 with the obligation to file the tax return.
12 And our military forces, including at Fort
13 Drum, who are preyed on by subprime predatory
14 auto lenders.
15 Additionally, there is a barrage of
16 new untested and unregulated financial
17 products like never before. Consumer debt is
18 at record levels. Student loan debt is at
19 record levels. Student debt is second only
20 to mortgages in terms of debt; it's above
21 credit card debt, it's above auto debt, and
22 the default rates are above them as well.
23 This is not only a problem for consumers,
24 it's a drag on the economy.

1 Most troubling -- perhaps we should
2 not be surprised -- many of these predatory
3 practices target disproportionately our most
4 vulnerable communities, which underscores the
5 need for us to act. In that regard, as I
6 close, let me quote from an op-ed that I was
7 honored to coauthor with Assemblyman Tremaine
8 Wright. "This agenda is more than just a
9 consumer protection agenda. It is an
10 economic and racial justice agenda that
11 focuses on alleviating historical disparities
12 and injustices that for too many years have
13 resulted in communities of color being denied
14 access to our financial system, targeted by
15 predatory lenders, and victimized by
16 perpetrators of deed and mortgage fraud, and
17 holding a disproportionate share of student
18 loan debt."
19 Thank you, Chair. I'd be happy to
20 take your questions.
21 CHAIRWOMAN KRUEGER: Thank you.
22 We're still waiting for Neil Breslin,
23 our chair of Insurance. So I'm going to jump
24 to -- actually, Gustavo, chair of Health, did

1 you have any questions? All right, then I'm
2 jumping to Senator Seward.
3 SENATOR SEWARD: Very good. I'm
4 flattered I'm the third choice here.
5 (Laughter.)
6 SENATOR SEWARD: Madam Superintendent,
7 it's good to see you again.
8 SUPERINTENDENT LACEWELL: Good to see
9 you, sir.
10 SENATOR SEWARD: And thank you for
11 your service in this new role.
12 I had a couple of questions
13 regarding -- in the prescription drug area.
14 There's language in the budget authorizing
15 investigations by the department with respect
16 to prescription drugs. And, you know, as I
17 read it, two events must occur concurrently
18 to trigger an investigation: An increase in
19 the price of the drug of 100 percent, and
20 suspicion of fraud.
21 Could you elaborate on that,
22 suspicions of fraud? I mean, what are we
23 really talking about here in terms of what
24 type of activities would trigger that?

1 SUPERINTENDENT LACEWELL: Thank you.
2 It's a pleasure to see you, Senator, and I
3 have enjoyed getting to know you a little bit
4 in this new role. So thank you.
5 Yes, you are correct, it is a two-part
6 test, call it what you will. But at least
7 the doubling of the drug within a one-year
8 period and indicia of fraud. The idea there
9 is the mere doubling of the drug price is not
10 enough by itself, because there may be
11 perfectly legitimate business reasons as to
12 why that occurred. And one could look to all
13 of those business-related reasons to
14 determine whether, you know, in context with
15 the rest of the industry, this is simply
16 something that's occurring for industry or
17 business-related or other innocuous purposes.
18 Or if there's some other indication
19 that something is wrong. I view it as a
20 guardrail around -- you don't jump into every
21 spike on a drug price. I'm a former federal
22 prosecutor, so I'm familiar with the indicia
23 of fraud. But I view that as a guardrail
24 around this potential new authority.

1 SENATOR SEWARD: Thank you.
2 How does this initiative in terms of
3 giving your department investigation
4 authority here, how does that relate to the
5 Attorney General's investigative powers? I
6 mean, is this overlap and duplication of
7 resources?
8 SUPERINTENDENT LACEWELL: I've been
9 pleased to work with our great Attorney
10 General even in the short time that I've been
11 at DFS, and we work very well together. I
12 don't believe that this in any way impinges
13 on her authority. And of course we would
14 work together with her where there would be
15 any potential overlap.
16 SENATOR SEWARD: One final question in
17 this area, prescription drugs. I know in the
18 Governor's State of the State message he
19 mentioned looking at importing drugs from
20 Canada at a less expensive rate -- and also
21 the insulin cap.
22 SUPERINTENDENT LACEWELL: Yes.
23 SENATOR SEWARD: Now, as I read the
24 budget, I don't find those in -- anything

1 related to those two in his budget proposal.
2 Would we be seeing something in the 30-day
3 amendments? Or where are we heading on those
4 two issues?
5 SUPERINTENDENT LACEWELL: Well, it may
6 be that there's an understanding that DFS by
7 regulation can cap the copays on insulin.
8 And it may also be with respect to the
9 Canadian drug importation that it's more a
10 matter that the agencies have to work
11 together, talk with the Canadians, talk with
12 the federal authorities. But I will ask the
13 Budget Division to get back to you on that.
14 SENATOR SEWARD: Okay, thank you.
15 Shifting over to PBMs, I know the
16 Governor vetoed a bill -- of course I did not
17 support the legislation when it passed the
18 Senate, because I saw some problems there and
19 agreed with the Governor, actually, on this
20 issue. But one of those was -- one of the
21 reasons for his veto was that the disclosure
22 requirements could jeopardize trade secrets
23 and conflicts with federal law that were
24 included in that legislation.

1 And under the proposal that's in the
2 budget, I note that disclosures to health
3 plans do not receive the same level of
4 confidentiality protections as the
5 disclosures required -- that go to the
6 superintendent. Is there a -- do you see a
7 discrepancy there or -- shouldn't we be
8 having confidentiality across the board in
9 terms of those trade secrets and conflicts
10 with federal law?
11 SUPERINTENDENT LACEWELL: Thank you
12 for that, Senator. I'll take that back. My
13 understanding, the primary issues with the
14 prior bill were concerns about ERISA
15 preemption and this fiduciary standard. But
16 you make a good point on that third point, so
17 we'll take that back.
18 SENATOR SEWARD: Okay, thank you. We
19 look for some clarification there later.
20 Just one final question. Can you
21 explain in a little more detail the code of
22 conduct provisions? And do you have any
23 concerns about increased costs, such as the
24 federal analysis of the fiduciary duties and

1 responsibilities? Would this code of conduct
2 trigger any increased costs associated with
3 the federal analysis?
4 SUPERINTENDENT LACEWELL: Well, I
5 think it is vitally important as a regulator
6 to balance the need to bring about consumer
7 protection and other kinds of protections in
8 markets and to consider what the cost is on
9 the other side. So we would be very mindful
10 of that.
11 The idea of the code of conduct is a
12 set of rules of the road that help to prevent
13 any kind of inappropriate practices that are
14 clear and transparent to the industry so that
15 they know what the rules are ahead of time
16 and they have that certainty. And I am
17 mindful of the need in issuing any
18 regulations, proposed regulations, to ensure
19 that balance. Right? We need industry, we
20 need businesses, we need jobs -- economic
21 development is actually part of the purview
22 of DFS in the statute. We also want to make
23 sure that we protect consumers to the fullest
24 extent possible.

1 CHAIRWOMAN KRUEGER: Thank --
2 SENATOR SEWARD: If I may, are you
3 going to, through regulation, develop the
4 code of conduct?
5 SUPERINTENDENT LACEWELL: I believe
6 that's right, under the bill. It's either
7 DFS or DFS and DOH together; I can't remember
8 as I sit here. But yes.
9 SENATOR SEWARD: Thank you.
10 CHAIRWOMAN KRUEGER: Thank you.
11 Assembly?
12 CHAIRWOMAN WEINSTEIN: To our
13 Insurance chair, Assemblyman Cahill.
14 ASSEMBLYMAN CAHILL: There we go, now
15 it's on.
16 Thanks for coming today. Hope this
17 meeting doesn't end as abruptly as our last
18 one did.
19 I see that the Governor is offering a
20 few new initiatives and a couple of
21 warmed-over proposals in his budget plan.
22 Our time here is limited, and there's a lot
23 to cover. I have about six areas that I want
24 to discuss. I'm not sure we're going to get

1 to them all.
2 So the first topic, or one of the
3 topics, is your -- is the annual request from
4 your department for powers currently reserved
5 to the Attorney General. I know my colleague
6 from the Senate just asked you about that; I
7 know my colleague who's the ranker on our
8 committee has some questions about that.
9 Revisiting of surprise bills and
10 independent dispute resolution, behavioral
11 health parity, pharmacy benefit management,
12 excess medical malpractice insurance and the
13 potential impact of a state-sponsored
14 individual insurance mandate.
15 I'd like to start with PBM and just
16 note that the Governor vetoed the
17 Gottfried-Breslin plan for PBM, and he cited
18 ERISA concerns and a few of the other matters
19 that you just raised. What was the role of
20 DFS, and your role in particular, at arriving
21 at the veto message and in crafting the
22 proposal that is before us today?
23 SUPERINTENDENT LACEWELL: Well,
24 obviously as a member of the cabinet, DFS

1 confers with the Governor's office, through
2 counsel's office and policy staff, with
3 respect to all proposals that intersect with
4 DFS. And every agency advises the Governor's
5 office with respect to bills that are sent to
6 him for consideration.
7 ASSEMBLYMAN CAHILL: So you had a
8 role, then, in --
9 ASSEMBLYMAN GOTTFRIED: Excuse me.
10 Could you pull the microphone closer?
11 SUPERINTENDENT LACEWELL: Me?
12 ASSEMBLYMAN GOTTFRIED: Yes.
13 Thank you.
14 ASSEMBLYMAN CAHILL: So then you had a
15 role in the crafting of the veto message and
16 also in the crafting of the proposal before
17 us. That's important to know.
18 SUPERINTENDENT LACEWELL: Well,
19 Assemblyman, I would not say that I had a
20 role in drafting it, nor would I get into
21 conversations between DFS and the Governor.
22 I'm saying that we always consult. That
23 doesn't mean that I drafted or had a role in
24 drafting.

1 ASSEMBLYMAN CAHILL: Oh. So can you
2 explain a little bit more what your
3 consulting role was in this process?
4 specifically with regard to PBM.
5 SUPERINTENDENT LACEWELL: Our role,
6 like any agency, is to advise the Governor's
7 office, counsel, the policy staff with
8 respect to matters in the experience of our
9 staff, on all matters that intersect with our
10 jurisdiction and authority. And that's what
11 we did. I -- many of those conversations, as
12 you know, Assemblyman, are privileged and
13 confidential, involving counsel, and I could
14 no more get into those deliberations than you
15 would want to get into your conversations
16 with the Senate.
17 ASSEMBLYMAN CAHILL: Well, I asked the
18 questions, with all due respect,
19 Superintendent, to frame the rest of my
20 questions to you to make sure that you
21 have -- that I'm asking you things for which
22 you have knowledge, as opposed to asking you
23 things that you'll be surmising or offering
24 an opinion on.

1 So we'll move to the next question on
2 that front. Do you believe and does the
3 Governor believe that PBMs should not have a
4 legally binding duty of care to consumers and
5 providers? I note that that's a difference
6 between the Gottfried/Breslin proposal and
7 the various proposals that have been offered
8 by the Governor's office.
9 SUPERINTENDENT LACEWELL: You spoke a
10 little too fast for me in the beginning. Do
11 I believe what?
12 ASSEMBLYMAN CAHILL: Do you believe
13 and does the Governor believe that PBMs
14 should not have a legally binding duty of
15 care to consumers and providers?
16 SUPERINTENDENT LACEWELL: Oh, I see.
17 To my understanding, there was a
18 concern that putting in a fiduciary duty with
19 respect to consumers could have the effect of
20 generating legal problems, and therefore we
21 would have no relief for consumers through
22 the bill.
23 So do I believe that all actors that
24 interact with consumers have obligations with

1 respect to consumers? I do. Can I
2 characterize that as a fiduciary duty in all
3 instances, depending on the panoply of
4 relationships that that entity has? I really
5 can't get that far.
6 ASSEMBLYMAN CAHILL: Well, I'll let
7 Assemblyman Gottfried re-explain his bill to
8 you. But there was nothing in there that
9 required a fiduciary obligation.
10 Were the Governor's proposals arrived
11 at with input from the industry and any
12 particular PBM? And in advance of that, did
13 you -- or at any point did you or anyone in
14 your agency have contact with any PBM or
15 their representative in developing your PBM
16 proposal?
17 SUPERINTENDENT LACEWELL: Well, you
18 have -- are you talking about this year or
19 last year?
20 ASSEMBLYMAN CAHILL: I'll talk about
21 any time you want.
22 SUPERINTENDENT LACEWELL: Well,
23 because remember, I came into office in
24 February of last year.

1 ASSEMBLYMAN CAHILL: Right.
2 SUPERINTENDENT LACEWELL: In the
3 middle of the budget process. So my
4 information --
5 ASSEMBLYMAN CAHILL: Okay, so since
6 you've been here.
7 SUPERINTENDENT LACEWELL: -- is pretty
8 limited.
9 ASSEMBLYMAN CAHILL: So the answer to
10 the question is did -- the question remains,
11 did you or anyone in your agency have any
12 contact or communications with anyone in the
13 PBM industry or any individual PBM in the
14 crafting of this proposal or anything about
15 the regulation of pharmacy benefit management
16 companies?
17 SUPERINTENDENT LACEWELL: When you say
18 "this proposal," which proposal do you mean?
19 ASSEMBLYMAN CAHILL: This proposal is
20 the one you're here to talk about today, the
21 one that's in the budget.
22 SUPERINTENDENT LACEWELL: The one
23 pending here now.
24 ASSEMBLYMAN CAHILL: Yes. And also,

1 by the way, as long as we're on the subject,
2 in the crafting of the veto message having to
3 do with the Breslin/Gottfried bill.
4 SUPERINTENDENT LACEWELL: Well, thank
5 you for that clarification, because that's
6 very helpful to me, because as I indicated, I
7 really just came into DFS in February of last
8 year, and that was a mid-budget process. So
9 I don't have any information -- I certainly
10 was not involved in the drafting of the veto
11 message. Leaving aside, of course, that the
12 agency, as I indicated, does advise the
13 Governor's office, like every other agency
14 does, with respect to bills that come across
15 the Governor's desk.
16 I don't have information about whether
17 any PBMs were individually consulted.
18 Obviously, there are only three of them.
19 I can, of course, say -- which I think
20 you are aware -- that CVS Caremark committed
21 that they would not oppose a PBM bill when
22 DFS was reviewing the merger. That of course
23 is before I came into DFS. That was under
24 the prior superintendent.

1 ASSEMBLYMAN CAHILL: But my question
2 is to you, have you had any contact with CVS
3 Caremark or any other PBM with regard to this
4 subject since that time?
5 SUPERINTENDENT LACEWELL: I have not.
6 ASSEMBLYMAN CAHILL: You have not.
7 Anybody in your office?
8 SUPERINTENDENT LACEWELL: I can get
9 back to you on that. I don't know as I sit
10 here.
11 ASSEMBLYMAN CAHILL: That would be
12 great if you could.
13 What is the budgetary impact of the
14 Governor's proposal to regulate pharmacy
15 benefit managers?
16 SUPERINTENDENT LACEWELL: The
17 budgetary impact would be none, because --
18 ASSEMBLYMAN CAHILL: None.
19 SUPERINTENDENT LACEWELL: -- any costs
20 would come through assessments. Which, as
21 you know, is how DFS is staffed.
22 ASSEMBLYMAN CAHILL: Okay, so -- so
23 there is not a budgetary relationship to this
24 PBM proposal, then, if I'm understanding your

1 answer correctly.
2 I just want to be clear whether this
3 is appropriate to be an Article VII in the
4 budget -- or maybe it should be handled
5 through separate legislation, as we've
6 proposed in the past.
7 SUPERINTENDENT LACEWELL: Well, I
8 don't know as I sit here if the Budget
9 Division is expecting any savings, given that
10 pharmaceutical prices are a driver. But I --
11 all of DFS is typically handled through the
12 budget, even though we are assessment-driven.
13 So I think it's entirely consistent with the
14 way that DFS is handled in the budget in all
15 years.
16 ASSEMBLYMAN CAHILL: But even though
17 you're assessment-driven, aren't the
18 assessments also included as part of the
19 overall state budget? Isn't it something
20 that would or would not be reflected in a
21 budget plan that's being advanced to the
22 Legislature? And is anything advanced to the
23 Legislature in that regard insofar as PBMs
24 are concerned?

1 SUPERINTENDENT LACEWELL: Yeah, that's
2 a good point. Thank you.
3 ASSEMBLYMAN CAHILL: Well, what's the
4 answer? I don't care about the point.
5 SUPERINTENDENT LACEWELL: Oh. I
6 thought you were making a point rhetorically.
7 But yes, of course, you're correct.
8 ASSEMBLYMAN CAHILL: No, that's other
9 people. I ask actual questions and hope we
10 get some actual answers once in a while.
11 SUPERINTENDENT LACEWELL: I do my
12 best.
13 ASSEMBLYMAN CAHILL: I'll move on
14 to -- just curious if this year are you aware
15 if there's any industry support or if once
16 again Caremark has indicated that they will
17 not oppose the Governor's proposal. Is that
18 still the case this year, as it was last
19 year?
20 SUPERINTENDENT LACEWELL: Yes.
21 ASSEMBLYMAN CAHILL: Okay. And last
22 year, as you might know -- because although
23 you were not in office that long, when the
24 PBM association came in to testify, they did

1 express some concerns about it. So let's
2 hope that they have figured out that circular
3 firing squad this year.
4 Let's move on to the question that I
5 don't know whether it is specifically lined
6 out in the budget. It was hinted at by a few
7 different folks associated with the budget.
8 And this has to do with the individual
9 mandate.
10 Is it a real idea being considered to
11 have a state individual mandate? And if so,
12 how much would it add or save to the budget?
13 SUPERINTENDENT LACEWELL: I -- I think
14 that that question is probably not within my
15 purview and is more of DOH. I don't have
16 information for you on that.
17 ASSEMBLYMAN CAHILL: Because an
18 individual mandate is whether someone is
19 required to get insurance or not. So I
20 thought maybe the commissioner -- the
21 superintendent who is in charge of insurance
22 would be able -- that's fine.
23 Let's talk about excess medical
24 malpractice. The program -- your regulatory

1 authority is being extended through June of
2 2021 under the Governor's proposal. The
3 funding for excess medical malpractice will
4 expire on June 30th of this year. How is it
5 proposed that the excess medical malpractice
6 insurance continue to remain affordable for
7 our hospitals that are on the ropes and our
8 providers, those specific providers who
9 qualify under the program?
10 SUPERINTENDENT LACEWELL: Well, I
11 expect that will be a matter of discussion
12 through the budget negotiations between the
13 Legislature and the Executive.
14 ASSEMBLYMAN CAHILL: So there is no
15 plan right now to make sure that it's
16 affordable after what the Governor put into
17 the budget that expires on June 30th?
18 SUPERINTENDENT LACEWELL: I don't have
19 information for you on that.
20 ASSEMBLYMAN CAHILL: Behavioral health
21 parity. From a regulator's point of view,
22 what exactly is the problem? And are you
23 using, to the fullest extent possible, the
24 existing tools that you have to enforce the

1 federal mandate?
2 SUPERINTENDENT LACEWELL: Well, we
3 were pleased that the mental health parity
4 bill was included last year and is in law,
5 and we've been doing a lot of work on that.
6 There have been a lot of complaints about
7 network adequacy and the ability of
8 individuals to actually access mental health
9 and addiction-related services. And this is
10 vitally important, and it is complex. It's
11 not just a matter of DFS, it's OASAS, it's
12 OMH, it's DOH.
13 And so to my understanding, the
14 thought is that all those agencies should get
15 together and provide clear direction and
16 guidance to the industry as to what the
17 compliance standards are for meeting that
18 parity. And we intend to act robustly in
19 that regard.
20 CHAIRWOMAN KRUEGER: Thank you.
21 ASSEMBLYMAN CAHILL: Thank you, Madam
22 Chair. I'll come back for my next five.
23 CHAIRWOMAN KRUEGER: Thank you. We've
24 been joined by Senator Carlucci and

1 Senator Sanders and by the chair of our
2 Insurance Committee, Senator Breslin, who is
3 up next for questions.
4 SENATOR BRESLIN: Good afternoon,
5 Superintendent Lacewell, and I apologize that
6 I had other commitments to get to before I
7 was able to get here. And if I duplicate any
8 questions, please feel free to correct me.
9 SUPERINTENDENT LACEWELL: Thank you,
10 sir.
11 SENATOR BRESLIN: I appreciate the
12 several conversations we've had, so you
13 already understand some of the things that I
14 do disagree with, which I would consider
15 numerous, but much of which came before you
16 became the superintendent. I would hope --
17 as I've told you, I felt that the veto of the
18 formulary bill, the veto of the PBM bill was
19 very, very anti-consumer, ill-advised, and
20 came out with a bad result that affects the
21 entire industry and does not protect the
22 consumer. Other than that, I liked it.
23 (Laughter.)
24 SENATOR BRESLIN: So is the -- one of

1 the problems that I've had with the
2 Department of Financial Services up until you
3 were appointed is that they're their own
4 people, they don't include the Legislature in
5 discussions, they feel as though they're
6 preemptive in the field, and we come up with
7 plans like the Prescription Drug Pricing and
8 Accountability Board, which has been touted
9 in descriptions of the upcoming budget, but I
10 think is more prosecutorially oriented than
11 dealing with things like the PBMs.
12 And I think that we will see a lot of
13 closings of independent pharmacy in the
14 coming year. And I would hope that during
15 the following six weeks that we can have
16 discussions between and among obviously the
17 chairman from the Assembly, myself, the
18 health people, to discuss the two principal
19 bills, PBM and the formulary bill.
20 And I assume that most of the
21 provocative questions, knowing Senator Seward
22 and Assemblyman -- the chairman of the
23 Assembly Insurance Committee, they've already
24 been asked. But I think that there's

1 probably a sense with this panel that there's
2 so much more that one of the most important
3 offices, DFS, can do in the area of pharmacy
4 benefits, pharmacy benefit managers,
5 formulary plans, and just the whole plethora
6 of issues that to me are very difficult for
7 the general public to understand, and it
8 places a greater burden on the financial
9 services and on the Legislature --
10 particularly the Legislature -- to do its due
11 diligence, perform in a way that makes it a
12 better, better world dealing with
13 pharmaceuticals and pricing and ethics within
14 the pharmacy benefit managers.
15 And unless there is total
16 accountability, I just don't want to see a
17 pharmacy benefit manager plan than gives the
18 name, rank and serial number. I want to make
19 sure that every possible element of their
20 ability to abuse is discussed properly
21 between and among the Legislature and the
22 DFS, to come up with the best possible piece
23 of legislation.
24 And I would hope that some of these

1 items aren't crammed down us in a budget that
2 obviously contains a lot more policy than the
3 people on this stage would like it to have,
4 and that we come up with a resolution in
5 these areas of something that's very
6 positive.
7 And I know that's more of a statement
8 than a question, but I'd appreciate your
9 response.
10 SUPERINTENDENT LACEWELL: Thank you,
11 Senator. I appreciate the statement.
12 I have expressed to you individually
13 and to a number of other members that I not
14 only recognize but I fully embrace the
15 importance of working together with you.
16 These are complex issues. You and other
17 members have deep experience on these issues
18 year after year.
19 The problems are complicated enough
20 that we're not going to arrive at the best
21 solutions unless we work it through together.
22 And I am committed to doing that, and that is
23 why I have been coming and having these
24 conversations.

1 And on a personal level, I appreciate
2 that even where we may disagree or where you
3 may be unhappy with the Executive or some
4 conduct, that we continue to have a
5 constructive professional working
6 relationship. And that is vitally important,
7 because there's so much work for us to do
8 together.
9 So I am delighted to work with you, to
10 work with others, whoever it's important to
11 have around the table, to work through these,
12 because I want to get it right too. At the
13 end of the day, it's in my hands.
14 SENATOR BRESLIN: Thank you. And I'll
15 limit my questions to that, assuming that the
16 others have been asked, and I'll ask for a
17 copy of the recording of participating and
18 working together, and I'll share it with some
19 of the other people in the Senate and send a
20 copy to you.
21 SUPERINTENDENT LACEWELL: Thank you,
22 sir.
23 SENATOR BRESLIN: Thank you.
24 CHAIRWOMAN KRUEGER: Thank you.

1 Assembly.
2 CHAIRWOMAN WEINSTEIN: To our Health
3 chair, Assemblyman Gottfried.
4 ASSEMBLYMAN GOTTFRIED:
5 Superintendent, you're licensed to practice
6 law, yes?
7 SUPERINTENDENT LACEWELL: Yes.
8 ASSEMBLYMAN GOTTFRIED: If you were in
9 private practice and a client found that you
10 were not providing legal services with care,
11 skill, prudence, diligence and
12 professionalism, you could get into real
13 trouble for that, couldn't you?
14 SUPERINTENDENT LACEWELL: Yes.
15 ASSEMBLYMAN GOTTFRIED: Yeah. So
16 would it be a problem to say that -- for the
17 law to say of PBMs that they should provide
18 their services with care, skill, prudence,
19 diligence and professionalism?
20 SUPERINTENDENT LACEWELL: No, I think
21 that's entirely appropriate.
22 ASSEMBLYMAN GOTTFRIED: And when we
23 were discussing the fate of the PBM bill with
24 the executive branch a month or so ago, one

1 of the demands was that those very words be
2 taken out of the bill.
3 SUPERINTENDENT LACEWELL: Well, there
4 may be a difference between a belief of how
5 actors should operate and the legal
6 consequence of using particular language in a
7 bill when it lands in front of a judge.
8 I know that you're aware of these
9 issues, and reasonable people can disagree on
10 the impact. But especially for a new law or
11 a new regulatory regime, legal risk is an
12 important factor because otherwise, if a new
13 protection is held up in the courts for a
14 long period of time, then we've simply
15 delayed arriving at the justice that all of
16 you are trying to generate.
17 ASSEMBLYMAN GOTTFRIED: But these are
18 words that, by common law, are a legal
19 mandate on shoe repair people and carpenters
20 and doctors and lawyers and real estate
21 agents. Why wouldn't we want that to be a
22 legal command on a PBM?
23 SUPERINTENDENT LACEWELL: Well, again,
24 I would say we may want that to be a legal

1 command on them, but if there are court
2 opinions that raise questions about the legal
3 viability of the language in the bill, then
4 again I would say we are just self-defeating.
5 There's an ability to take a close look at
6 what the practices are and to generate
7 regulations and do this with full visibility
8 into what the practices are and hopefully
9 arrive at the same result.
10 ASSEMBLYMAN GOTTFRIED: So you think
11 if we had a bill to require carpenters to
12 exercise skill and care, et cetera, that the
13 carpenters might be able to sue to get that
14 overturned? I mean, that's really strange.
15 SUPERINTENDENT LACEWELL: Well, I'm
16 not trying to defend any legal opinions out
17 there that raise concerns about the viability
18 of such a standard. I'm simply saying that
19 if there are legal opinions out there that
20 raise concerns about the viability of the
21 standard, then all we do is delay achieving
22 the reform that the members and the Executive
23 appropriately want to achieve.
24 And so if we can do it in a cleaner

1 manner where the bill doesn't end up getting
2 held up, even though it's signed into law,
3 then that's all to the better, justice
4 delayed is justice denied, and let's just get
5 it done.
6 ASSEMBLYMAN GOTTFRIED: Are you
7 familiar -- and I don't know that I have ever
8 had the experience of citing favorably the
9 work product of the current U.S. Justice
10 Department. But are you familiar with the
11 amicus brief filed by the Justice Department
12 with the Supreme Court in support of the
13 Arkansas PBM statute? Which is remarkably
14 similar to the one that just got vetoed in
15 New York.
16 SUPERINTENDENT LACEWELL: I'm happy to
17 take a look at it. I haven't seen that
18 particular brief.
19 I'm aware, obviously, that the issue
20 is being litigated across the board, and I'm
21 happy to take a look at that.
22 ASSEMBLYMAN GOTTFRIED: Okay. Because
23 it is to me an astonishingly lucid and
24 sensible document. Only the astonishment, of

1 course, is just because of the current
2 administration in Washington.
3 But I think it makes perfectly clear
4 that -- and coming from, you know, the
5 current Washington administration's Justice
6 Department, makes perfectly clear that the
7 legislation, the PBM bill that got vetoed, is
8 actually on -- would actually be on
9 enormously solid ground.
10 So I would commend that to you.
11 SUPERINTENDENT LACEWELL: I'll take a
12 look.
13 ASSEMBLYMAN GOTTFRIED: Okay, thank
14 you.
15 SUPERINTENDENT LACEWELL: Thank you,
16 sir.
17 CHAIRWOMAN KRUEGER: You're done
18 with your --
19 ASSEMBLYMAN GOTTFRIED: I'm done.
20 Yes, I'm done.
21 CHAIRWOMAN KRUEGER: Only seconds to
22 spare. Thank you.
23 Senator Savino for the next questions.
24 SENATOR SAVINO: Thank you,

1 Senator Krueger.
2 Good afternoon, Superintendent.
3 I'm going to ask you a question that I
4 asked the Commissioner of Health, about the
5 long-term-care program, because one of the
6 largest driving forces in the increase in
7 Medicaid spending is on long-term care. And
8 so there's only a 30-day lookback period for
9 long-term-care Medicaid services, where
10 there's a five-year lookback for nursing
11 homes. So I'm just wondering, is there any
12 idea that maybe we should change that and
13 line them up?
14 Or also, what are we doing to
15 incentivize insurers to provide lower-cost
16 long-term-care insurance? I hear from many
17 of my constituents who had the wisdom to buy
18 it that the premiums have gone up
19 significantly in the past couple of years,
20 and they've been approved every time by the
21 Department of Financial Services. And it's
22 putting them in a position where they're now
23 considering dropping the long-term-care
24 insurance just at the point in their life

1 when they really probably will need it.
2 So what can we do to bring these
3 products into the marketplace in a fairer way
4 so that people who need them can purchase
5 them?
6 SUPERINTENDENT LACEWELL: Thank you,
7 Senator. Long term care insurance, as you
8 know, is a national problem, it's a national
9 crisis. New York is in a little better
10 position than many other states because the
11 oversight tends to be more robust in New York
12 State.
13 I've had conversations with other
14 members, including Senator Krueger, about
15 this problem.
16 I think that -- well, first of all,
17 with respect to the rates, I don't believe
18 that DFS has simply approved the rate
19 proposals. We have approved increases, but
20 not at the level that's been requested. And
21 unfortunately, we have an obligation in that
22 regard to ensure the solvency of the insurer
23 in question. So we have to strike that
24 balance of approving only as much, you know,

1 as can be justified with an eye toward the
2 solvency.
3 And obviously I am painfully aware
4 that it is the consumer, it's the insured who
5 is left with the impact on this. Obviously
6 the product was underpriced many years ago.
7 Everyone here is deeply familiar with what
8 the problems are -- rising cost of insurance,
9 the low interest rates, the lapse rates being
10 less than expected.
11 I think you're also probably aware
12 that one of the things offered to consumers
13 who have had these policies for many years is
14 an ability to sort of reshape the benefits,
15 known as landing spots. Which is not ideal
16 either, but at least it keeps the policy in
17 force.
18 There's no question that we have got
19 to focus on this problem, both with respect
20 to the old policies and making sure that new
21 policies, appropriately priced, are available
22 for consumers. And I think that there are
23 some creative ideas emerging about different
24 ways of offering this kind of product in the

1 marketplace. I don't think any of them are
2 ready for prime time.
3 We're having conversations with the
4 Department of Health; be happy to work with
5 you and the Department of Health and anyone
6 else who's interested, to drill down on
7 these.
8 SENATOR SAVINO: I would appreciate
9 that.
10 And finally, even though it's not the
11 subject of this -- as you know, the medical
12 marijuana program has been in existence five
13 years now. And when it opened, it was
14 somewhat the Wild West out there with respect
15 to insurance coverage. Now we know it
16 doesn't pay for, insurance will not pay for
17 the product. But many physicians out there
18 that are providers are making up the rules as
19 they go along.
20 Your predecessor was kind enough to
21 prepare an article to send out to doctors to
22 tell them that they cannot charge patients
23 for the patient visits, and they seem to be
24 ignoring it. So they're charging -- they're

1 just making it up -- $500 for a visit, $500
2 to prepare the application for being approved
3 by a patient.
4 So I would hope that you will work
5 with me to come up with some way to send that
6 message out there that while insurance
7 doesn't pay for the medical marijuana, you're
8 not supposed to charge patients cash for
9 visits when they have an insurance policy.
10 SUPERINTENDENT LACEWELL: Absolutely,
11 we'll work with you on that, Senator. Thank
12 you.
13 SENATOR SAVINO: Thank you.
14 CHAIRWOMAN KRUEGER: Okay, Assembly.
15 CHAIRWOMAN WEINSTEIN: We go to
16 Assemblyman Jacobson.
17 ASSEMBLYMAN JACOBSON: Thank you,
18 Madam Chair.
19 I want to view another area that your
20 department has, and that's concerning the
21 review of denial of prescriptions and medical
22 procedures. The process is called an
23 external appeal. I mean, what happens is if
24 somebody gets denied, they go through their

1 insurance company, their internal process,
2 then they have the external appeal. At best,
3 your process is incomplete, because what
4 happens is you outsource the decision-making.
5 And in the case that my constituent had, it
6 was outsourced to an outfit called IMEDICS.
7 They gave the facts to three different IMEs.
8 Two came back affirming the denial, one came
9 back saying it should have been approved.
10 And this was a situation for hydrogel.
11 The patient was involved in prostate cancer
12 treatment, and this protects you.
13 So the problem is -- so we wrote
14 letters and said that someone's got to review
15 it, because the credibility of the two
16 reports that denied it was terrible. I mean,
17 you had it -- they were relying on outdated
18 reports, they referred to the prescription of
19 the medication as experimental, yet it was --
20 has been approved by the FDA.
21 So -- and I know from my experience as
22 a workers' comp judge and practicing workers'
23 comp law for many years, IMEs, independent
24 medical exams, they're not like God speaking.

1 I mean, they go there, they do their work,
2 they're overwhelmed.
3 So I wrote a letter attacking the
4 credibility. And everybody was very polite
5 in your office -- I mean, they were all
6 polite and got back to us. And then the
7 decision was, Well, we have no power. So
8 what is it? You outsource it, they come back
9 with faulty IMEs that the decision has relied
10 on, and then you don't review it.
11 So my question is is that you -- are
12 you saying you don't have the power to do
13 that?
14 SUPERINTENDENT LACEWELL: So,
15 Assemblyman, thank you for bringing that to
16 our attention. And obviously we had a chance
17 to speak for a few moments earlier today, and
18 I know our staff has been working with your
19 staff.
20 It is very important that we do
21 everything we can to improve the accuracy of
22 the basis of the decisions that are reached
23 in any of these administrative proceedings
24 and that we have appropriate safeguards in

1 place and sufficient due process so that
2 going to court is a last resort, because I
3 know that's outside the reach of many.
4 So we are going to take a close look
5 at our processes are and what our authorities
6 are and what other agencies do and what other
7 systems do, and see what we can do to bring
8 about greater reliability in that process.
9 ASSEMBLYMAN JACOBSON: I will be
10 introducing legislation. But the problem
11 here is that nobody there is reviewing your
12 outsource decision. So the decision comes
13 back, and it's there, so you say, Okay, it
14 still is going to be denied because that's
15 what two out of three IMEs said.
16 But the IMEs that were writing were
17 clueless. They were using outdated reports
18 that were contradicted by another report that
19 the one IME that approved it cited. And like
20 I mentioned, they said it was experimental.
21 And so what there has to be is
22 something -- I can't believe I'm going to say
23 these next words -- similar to workers'
24 compensation, which has its own problems, but

1 at least there is a semblance of a fair
2 procedure when you go from the trial level to
3 a review panel to the full review by the
4 commissioners.
5 SUPERINTENDENT LACEWELL: Thank you,
6 Assemblyman. And as I indicated, we're going
7 to work with you on that, and we'll see what
8 we can do to bring about a better process.
9 ASSEMBLYMAN JACOBSON: All right,
10 thank you.
11 CHAIRWOMAN WEINSTEIN: Senate? Oh,
12 I'm sorry, before we go to the Senate I just
13 wanted to acknowledge that Assemblyman Félix
14 Ortiz joined us a little while ago.
15 CHAIRWOMAN KRUEGER: Great. And we're
16 rejoined by Senators Jackson, I think I said
17 Sanders already. And Senator Gallivan is up
18 next.
19 SENATOR GALLIVAN: Thank you. Good
20 afternoon. I want to touch on two areas.
21 Both the Governor mentioned, but I don't
22 believe that they actually appeared in this
23 proposed budget.
24 The first had to do with the

1 importation of prescription drugs from
2 Canada. Do you know what the proposal is,
3 and will it be included in the 30-day
4 amendments?
5 SUPERINTENDENT LACEWELL: So the
6 proposal, as I understand it, is to consider
7 going through a process of speaking with
8 authorities in Canada and speaking with
9 relevant federal authorities to see whether
10 there is a viable proposal to put forward for
11 approval to allow the importation.
12 Some localities have done this,
13 apparently. And so I think the Governor was
14 putting this forward and being transparent
15 that this is something that we would be
16 seeking to do.
17 So to my understanding, that's why you
18 would not have seen particular language on
19 it, but it's wrapped together with his other
20 initiatives to do something about the high
21 cost of prescription drugs.
22 SENATOR GALLIVAN: Do you know if
23 we'll see it in the amendments?
24 SUPERINTENDENT LACEWELL: I will ask

1 the Division of Budget to get back to you on
2 that. That question did come up a little
3 earlier, and I did commit to do that.
4 SENATOR GALLIVAN: The other -- same
5 general area -- he mentioned a cap on
6 insulin, on the price of insulin or copays.
7 Do you know what the specific proposal is, or
8 will we see it?
9 SUPERINTENDENT LACEWELL: To my
10 understanding, the concept is that DFS would
11 issue regulations in that regard, or other
12 legal authority to industry to cap that, and
13 that we have the authority to do so.
14 So again, I think the Governor was
15 being transparent about the range of items
16 that would be sought to address the high cost
17 of prescription drugs.
18 SENATOR GALLIVAN: Okay, thanks.
19 Going back to PBMs and the proposal
20 related to that, in particular, it calls for
21 an assessment on the PBMs to cover increased
22 costs, administrative costs for DFS. Do you
23 have any concern that this -- or how do we
24 know that this will not actually raise the

1 cost of prescription drugs for the consumer?
2 SUPERINTENDENT LACEWELL: Well, thank
3 you for the question. Of course it's the
4 last thing we want to do. But as I'm sure
5 you are aware, the way that DFS is funded is
6 through assessment on industry and not
7 through taxpayer dollars.
8 And so where we have additional work
9 to do, we have to have people to do the work,
10 and that cost is borne by the industry that's
11 being regulated.
12 Typically those costs would not be so
13 large as to do something so impactful as to
14 affect prices. And additionally, alongside,
15 obviously, the idea is that these various
16 measures together are a way of helping
17 stabilize or bring down drug prices.
18 SENATOR GALLIVAN: I suppose it's
19 really too early without seeing specifics or
20 seeing numbers, but I think that's a concern
21 to be aware of.
22 SUPERINTENDENT LACEWELL: All right,
23 thank you.
24 SENATOR GALLIVAN: Thank you. Thank

1 you, Madam Chair.
2 CHAIRWOMAN KRUEGER: Thank you.
3 Assembly.
4 CHAIRWOMAN WEINSTEIN: So we've been
5 joined by Assemblywoman Hunter, and we go to
6 Assemblyman Garbarino for questions.
7 ASSEMBLYMAN GARBARINO: Thank you,
8 Chairwoman.
9 I just want to follow up again, I know
10 Chairman Cahill asked you about the medical
11 malpractice extender. Now, I don't
12 understand, it's dropping about 22 million
13 from last year to this year's budget
14 appropriation. Why is that?
15 SUPERINTENDENT LACEWELL: I'll have to
16 get back to you on that. I'm just not
17 familiar with the -- with those numbers.
18 ASSEMBLYMAN GARBARINO: Okay. Why
19 isn't it being extended? I know he tried to
20 ask, and I didn't really hear the answer.
21 SUPERINTENDENT LACEWELL: I think what
22 he was saying is that DFS authority is being
23 extended, but is the money being extended in
24 parallel.

1 ASSEMBLYMAN GARBARINO: Okay. So but
2 it's -- from my reading, it doesn't extend
3 past June, though, correct, the authority to
4 purchase?
5 SUPERINTENDENT LACEWELL: Correct.
6 ASSEMBLYMAN GARBARINO: Why not?
7 SUPERINTENDENT LACEWELL: I think the
8 idea is that these are all matters under
9 discussion, and this would be a matter, I
10 think, to be discussed between the
11 Legislature and the Executive. Although I am
12 happy to go back and see if I can get answers
13 to some of these questions to make it a
14 little easier for you.
15 ASSEMBLYMAN GARBARINO: Now, is
16 this -- I've heard rumors, but I don't know
17 if it's true. Is this something that they're
18 hoping to discuss under MRT II?
19 SUPERINTENDENT LACEWELL: Yes, I think
20 that the MRT -- the concept is the MRT is
21 opening to considering issues affecting
22 medical malpractice.
23 ASSEMBLYMAN GARBARINO: Okay, so is
24 somebody from DFS going to be on MRT II?

1 SUPERINTENDENT LACEWELL: I'm not
2 aware at this time.
3 ASSEMBLYMAN GARBARINO: Because I
4 looked at the last MRT, and nobody from the
5 Department of Insurance or -- I think DFS was
6 created afterwards -- nobody was on MRT I.
7 So if we're going to be discussing
8 medical malpractice insurance and other
9 things at MRT II, I would hope maybe someone
10 from your department, if not you --
11 SUPERINTENDENT LACEWELL: Well, and if
12 not, certainly we would confer as appropriate
13 and as needed.
14 ASSEMBLYMAN GARBARINO: You regulate
15 and approve increases in health plan
16 insurance premiums, correct? If they're
17 requesting an increase, you have to approve
18 it?
19 SUPERINTENDENT LACEWELL: Yes.
20 ASSEMBLYMAN GARBARINO: Now, MRT II,
21 there's a -- in discussions they have to
22 raise $2.5 billion by April 1st. If there's
23 a -- do you think it's appropriate for them
24 to discuss possible increases in taxes on

1 health plans?

2 SUPERINTENDENT LACEWELL: Well, the

3 MRT of course is Medicaid-cost-related and we

4 regulate commercial health insurance plans.

5 So I think that that's really more a matter

6 for Medicaid and the Department of Health and

7 the Division of the Budget.

8 ASSEMBLYMAN GARBARINO: But if

9 Medicaid decides -- I know you regulate

10 commercial health, but if Medicaid {sic}

11 decides to raise taxes on these commercial

12 plans, they have to then, to make up that

13 cost, they might have to ask for premium

14 increases, which reflects back to you.

15 SUPERINTENDENT LACEWELL: Oh, I see.

16 I misunderstood your question.

17 To my understanding, I believe the

18 Budget Director was asked if such taxes were

19 contemplated, and he didn't rule it out. So

20 I -- we would defer to allow the process to

21 unfold. Obviously, there will be many

22 conversations to sort through a lot of these

23 issues, and I would not want to be disruptive

24 of that process by presupposing that that's

1 on the table.
2 ASSEMBLYMAN GARBARINO: Okay. But
3 again, if MRT II discusses possible increases
4 in taxes to these health plans, do you think
5 it would be appropriate to have someone from
6 DFS on MRT II?
7 SUPERINTENDENT LACEWELL: Certainly we
8 would like to be a part of the dialogue. I
9 don't know if membership is needed. But
10 certainly I would expect that anything
11 affecting commercial health insurers, that
12 DFS would be consulted. And I have no reason
13 to believe that that would not happen.
14 ASSEMBLYMAN GARBARINO: Okay, thank
15 you.
16 CHAIRWOMAN WEINSTEIN: Senate?
17 CHAIRWOMAN KRUEGER: Thank you.
18 Hi. We've gotten to me.
19 So the Governor's budget proposal
20 includes portions of a bill some of us
21 carried in both houses, the Patient Medical
22 Debt Protection Act, but not Part G of our
23 bill, which would hold consumers harmless
24 from plan or provider misinformation.

1 Can you explain why the Governor
2 didn't include Part G from our bill?
3 SUPERINTENDENT LACEWELL: I
4 unfortunately cannot shed light on why that
5 would not be included. Obviously changing
6 the statute of limitations, if that's what
7 you're referring to in the first part, is
8 vitally important to reduce that to something
9 reasonable for consumers. I am of course
10 generally in favor of more consumer
11 protection across the board. And I'm happy
12 to confer with the chamber -- obviously, you
13 have the ability and I'm sure you are
14 yourself, but I'm happy to talk to them.
15 CHAIRWOMAN KRUEGER: But I would love
16 if you could take a look at the original
17 bill, take a look at the Governor's proposal,
18 and if you agree Part G is important, urge
19 him, as a representative of his
20 administration, to add Part G in his 30-day
21 amendments. Because I think we actually
22 would all agree on the whole package.
23 SUPERINTENDENT LACEWELL: Okay. Thank
24 you.

1 CHAIRWOMAN KRUEGER: Okay? Thank you.
2 He also talked about, in his State of
3 the State, but then I didn't find it anyplace
4 in the budget, which requires disclosure of
5 the facility fees in medical billing. Which
6 seems to me is probably your territory also.
7 Can you explain to me why he talked
8 about it -- and I agree with him -- but then
9 I couldn't find it anywhere in the budget?
10 Is it something you just do through
11 regulation, it doesn't need to be in the
12 budget?
13 SUPERINTENDENT LACEWELL: I believe
14 that that's the understanding, and I'm going
15 to confirm that. I believe DFS could do that
16 through regulation. And again, that's the
17 Governor being transparent about his
18 intention in that regard. But I will get
19 back to you on that.
20 CHAIRWOMAN KRUEGER: Thank you.
21 Appreciate that as well.
22 So people have asked about insulin and
23 the PBMs. So there's still a debate in both
24 houses around the concepts of surrogacy and

1 legality of surrogacy, and I have my own
2 bill, but I don't think it should be part of
3 the budget. But if the Governor's proposal
4 for surrogacy were to become the law, there's
5 a set of requirements for insurance coverage
6 for surrogates --
7 SUPERINTENDENT LACEWELL: Yes. Yes.
8 CHAIRWOMAN KRUEGER: -- and for
9 actually, in my version, for egg donors as
10 well, who put themselves at risk being egg
11 donors.
12 Do we have any law that would require
13 insurance policies for -- in a surrogate
14 situation because it's not a, quote, unquote,
15 traditional family model or specifically for
16 egg donors, or are you going to need to come
17 up with new regulations, slash, law separate
18 than I think anything we've seen yet to
19 ensure that we have the correct insurance
20 coverage existing in New York?
21 SUPERINTENDENT LACEWELL: So to my
22 understanding, the provision in the Governor's
23 Executive Budget with respect to health
24 insurance -- and by the way, potentially life

1 insurance for the surrogate -- is simply
2 articulating and providing the right of the
3 surrogate to have this insurance and have it
4 paid for by the intended parents.
5 With respect to the coverage itself,
6 there would be nothing unusual about that
7 type of insurance policy. And the role of
8 DFS, as I see it, would be to issue guidance
9 to industry to insure that they understand
10 that and that they are making available the
11 existing policies they have without
12 discrimination because of the fact that it
13 happens to be in the context of surrogacy.
14 CHAIRWOMAN KRUEGER: Okay. There are
15 some other people who seem to believe it's a
16 bigger problem than that, so I will have them
17 follow up with you.
18 SUPERINTENDENT LACEWELL: All right.
19 CHAIRWOMAN KRUEGER: But again, for my
20 purposes, there's still great debate about
21 many of the pieces of surrogacy, and we
22 shouldn't be rushing it through the budget.
23 Ah. The program that we refer to as
24 the Medical Indemnity Fund, which was DFS's

1 from the beginning up until, sometime this
2 year, some pieces of it got transferred to
3 DOH. But I think you're the right one to
4 ask.
5 The budget does not include annual
6 funding from HCRA continuing to go into the
7 fund. When we created this, which was for
8 babies who were born damaged but instead of
9 the families going through the medical
10 malpractice court process, we were creating a
11 insurance fund guaranteeing that adequate
12 healthcare would be provided for their babies
13 till -- for as long in their life as they
14 needed the supplemental healthcare.
15 And I believe that HCRA was scheduled
16 to contribute 51 or $52 million this year,
17 but in the Governor's budget we're skipping
18 that.
19 One -- a couple of questions and
20 follow-up. One, this program was never
21 designed so that the taxpayer picked up the
22 cost. It was the hospitals agreeing to pick
23 up the cost so that they did not have to deal
24 with these cases one by one in medical

1 malpractice cases through the court, one.
2 Two, it's not at all clear that
3 there's an adequate funding stream into the
4 outyears, considering 70 to 80 children are
5 being added per year.
6 And three, we had provided an enhanced
7 provider rate when we learned there were very
8 few providers who were willing to take on
9 these children at the lower Medicaid rates,
10 and that's also sunsetting. So are we going
11 to make sure we have the adequate provider
12 enhanced rate continuing? We've got money
13 coming in through HCRA to make sure this fund
14 is not running dry.
15 And again, I'm not exactly sure what
16 part of it went to DOH, but I see you as the
17 correct agency to be asking the questions of.
18 SUPERINTENDENT LACEWELL: Thank you,
19 Senator.
20 Well, the budget last year formally
21 transferred the program to DOH effective
22 October 1st of last year, and that transfer
23 is complete. So I will need to get with DOH
24 and the Division of the Budget and ensure

1 that we get you the answers to these
2 questions and that your concerns are
3 appropriately conveyed.
4 CHAIRWOMAN KRUEGER: So your agency
5 had done a study on the projected long-term
6 costs of this program at the growth rate it
7 was going at. So did those functions also
8 then move over to DOH, or are they supposed
9 to keep asking you those kinds of questions?
10 Because again, it's an indemnity fund,
11 like other insurance. And I don't know that
12 DOH is in the business of knowing how to
13 evaluate -- I mean, not a criticism of them,
14 I just think DFS is who evaluates whether
15 there is, you know, adequate resources and
16 insurance.
17 SUPERINTENDENT LACEWELL: Right.
18 CHAIRWOMAN KRUEGER: And DOH doesn't.
19 So I'm concerned that whatever reason it
20 moved to DOH, they're not the ones to
21 actually stay on top of this over time.
22 SUPERINTENDENT LACEWELL: All right, I
23 understand what you're saying. We'll come
24 back to you.

1 CHAIRWOMAN KRUEGER: Thank you very
2 much.
3 Assembly.
4 CHAIRWOMAN WEINSTEIN: Assemblyman
5 Abinanti.
6 ASSEMBLYMAN ABINANTI: Hello,
7 Superintendent. Nice to see you again.
8 SUPERINTENDENT LACEWELL: The same.
9 ASSEMBLYMAN ABINANTI: We had a chance
10 to chat the other day, and -- but I guess
11 we're in a more formal environment now.
12 I'd like to take a look at the big
13 picture first. As I understand, your budget
14 is pretty much flat, but you have a
15 $1.3 million increase in your budget. Is
16 that correct?
17 SUPERINTENDENT LACEWELL: Additional
18 FTEs, perhaps.
19 ASSEMBLYMAN ABINANTI: Correct, okay.
20 Now, how much of the additional cost is
21 attributable to the expansion of enforcements
22 that you're looking at that you've proposed
23 here in the health field? And I notice in
24 the banking area there's four Article VII

1 proposals, all of which will expand your
2 functioning and your responsibilities.
3 Is that why you're going to have the
4 $1.3 million increase?
5 SUPERINTENDENT LACEWELL: Well, I
6 don't have the ability to break it down right
7 now. But certainly as we take on additional
8 responsibilities, that requires additional
9 personnel and that generally results in
10 assessments to the industry, and that gets
11 captured in the overall budget.
12 But I'm happy to confer internally and
13 have appropriate staff sit with your staff to
14 walk you through it.
15 ASSEMBLYMAN ABINANTI: Yeah, I would
16 like to do that. Because you are saying to
17 this panel of legislators that you're going
18 to be able to do all of the things that you
19 promise in here, and that you have the staff
20 to do that. And I'm frankly concerned about
21 giving power to an office that doesn't have
22 the capacity to handle the new work.
23 SUPERINTENDENT LACEWELL: Understood.
24 ASSEMBLYMAN ABINANTI: And -- for

1 example, do you have -- how many lawyers do
2 you have on staff? How many litigators do
3 you have a staff?
4 SUPERINTENDENT LACEWELL: Well, that's
5 a tough question, because in addition to our
6 general counsel, we have lawyers who are
7 seeded through -- S-E-E-D-E-D, seeded
8 through -- the other bureaus and divisions.
9 And we have about 1335 individuals across the
10 board. We have many examiners, many lawyers.
11 ASSEMBLYMAN ABINANTI: Right. But
12 you're asking for additional power in
13 general.
14 SUPERINTENDENT LACEWELL: Yes.
15 ASSEMBLYMAN ABINANTI: We can deal
16 with that separately from the Banking
17 Committee. But even here today, you're
18 talking about subpoena power, you're talking
19 about hearings, you're talking about all
20 kinds of things that I'm assuming you're
21 going to need lawyers for.
22 SUPERINTENDENT LACEWELL: Yes. And of
23 course --
24 ASSEMBLYMAN ABINANTI: So I'm kind of

1 probing here to see, you know, what resources
2 you have to do this stuff you're talking
3 about.
4 SUPERINTENDENT LACEWELL: Right.
5 Well, I think that we issue subpoenas now, we
6 do hearings now, and a whole range of things,
7 and this would be an additional subject
8 matter that many of those same lawyers would
9 be engaged in those activities.
10 But then, in addition, the concept is
11 if you're regulating a new segment of
12 industry, you'll need some additional
13 personnel in that regard.
14 ASSEMBLYMAN ABINANTI: Right. But
15 isn't the Attorney General's office doing
16 some of the things that you want to take over
17 doing?
18 SUPERINTENDENT LACEWELL: No, I don't
19 believe that's correct, sir.
20 ASSEMBLYMAN ABINANTI: Well, we're
21 talking here about, for example, the
22 increased authority with respect to
23 prescription drugs. And you want to issue
24 subpoenas, refer investigations, hold

1 hearings.
2 That was a state law that you're
3 talking about enforcing, right?
4 SUPERINTENDENT LACEWELL: Well --
5 ASSEMBLYMAN ABINANTI: Wouldn't the
6 Attorney General's office be doing that
7 otherwise?
8 SUPERINTENDENT LACEWELL: There are
9 multiple -- as you know, Assemblyman, there
10 are multiple authorities across the state
11 that can conduct investigations and issue
12 subpoenas and engage in enforcement. And
13 simply because something is a matter of
14 investigation and enforcement doesn't
15 diminish the ability of another authority to
16 look at a question if that's within their
17 purview and is a priority of theirs.
18 And as I indicated earlier, we have a
19 very good relationship with our great
20 Attorney General. And by the way, she's our
21 lawyer, right, she represents us in
22 litigation. We have a great relationship.
23 We've brought matters together with her, and
24 I'm not anticipating --

1 ASSEMBLYMAN ABINANTI: Let me jump to
2 another area. I want to follow up on the
3 Senator's question about the MIF. Now, it
4 was transferred from you to the Health
5 Department.
6 SUPERINTENDENT LACEWELL: Yes.
7 ASSEMBLYMAN ABINANTI: Did you
8 transfer the funding and the personnel that
9 were operating that, or do they remain on
10 your staff?
11 SUPERINTENDENT LACEWELL: Well, I
12 don't know that there were personnel that
13 were dedicated to the MIF that would be
14 transferred over. But I'm going to drill
15 down on that, which I already need to do,
16 given the prior question, and I'll --
17 ASSEMBLYMAN ABINANTI: The Behavioral
18 Health Parity Compliance Fund, which is in
19 your comments, is that going to be new monies
20 coming in?
21 SUPERINTENDENT LACEWELL: Yes. The
22 concept is that if there are penalties that
23 come in due to violations of these --
24 ASSEMBLYMAN ABINANTI: Will those be

1 going into the General Fund or a separate
2 fund outside the budget?
3 SUPERINTENDENT LACEWELL: I believe
4 that the proposal is that those would go into
5 a particular fund to be used --
6 ASSEMBLYMAN ABINANTI: But outside the
7 General Fund, outside the budget, to finance
8 enforcement? Or are we talking about money
9 that's just going to be coming into the
10 General Fund and you're going to do the
11 enforcement with your present staff?
12 SUPERINTENDENT LACEWELL: As proposed,
13 the money would go into a fund that would be
14 dedicated to the matter that is being
15 regulated in that regard. Not into the
16 General Fund.
17 ASSEMBLYMAN ABINANTI: Can you give us
18 an estimate of how much money you expect to
19 come in?
20 SUPERINTENDENT LACEWELL: I couldn't
21 begin to estimate.
22 ASSEMBLYMAN ABINANTI: Could you give
23 it to us later?
24 SUPERINTENDENT LACEWELL: I will look

1 at it and come back to you, certainly.
2 ASSEMBLYMAN ABINANTI: Thank you.
3 SUPERINTENDENT LACEWELL: Thank you,
4 sir.
5 CHAIRWOMAN WEINSTEIN: Thank you.
6 We go to Assemblyman Byrne.
7 ASSEMBLYMAN BYRNE: Thank you. And
8 thank you, Superintendent, for being here and
9 being so patient, sitting there and answering
10 our questions.
11 Just looking at some of your testimony
12 regarding the high cost of prescription drugs
13 are the largest driver of premium rates --
14 and we know there's many factors. Obviously,
15 the cost of medicine is one of them. I would
16 suggest maybe mandated benefits could
17 increase costs as well as taxes. So that was
18 kind of one of my questions to start with.
19 The health plans released a report
20 indicating New York taxed health insurers
21 $5.2 billion last year through the covered
22 lives assessment, the HCRA surcharge premium
23 tax. And my understanding is the HCRA tax is
24 actually the third largest state tax behind

1 only the personal income tax and sales tax.
2 And if we're concerned about
3 increasing premiums and the cost of insurance
4 for consumers, would the administration at
5 least be -- would they be willing to consider
6 a moratorium, holding a line on those taxes?
7 Because as was mentioned earlier with MRT II,
8 there is some concern about dipping into
9 things as revenue raisers, and ultimately
10 that could increase the cost of premiums for
11 consumers. So is that something that you
12 would be able to do?
13 SUPERINTENDENT LACEWELL: Well, thank
14 you, Assemblyman. So obviously healthcare
15 products and services are a large part of the
16 economy, generate a lot of jobs, a lot of
17 economic activity and, as you indicate,
18 generate fees and a tax base to help provide
19 the infrastructure for these benefits going
20 to individuals downstream.
21 The idea of the prescription drug
22 regulation or regulatory package is that the
23 prices of the prescription drugs may in some
24 instances be unchecked, and that it is

1 important enough, because it is such a cost
2 driver, that we need to understand the
3 reasons, we need to have guardrails around
4 it, we need to set out what the practices
5 should be, we need to understand what the
6 pricing models are, what's effective, where
7 the costs are being imposed. And --
8 ASSEMBLYMAN BYRNE: I'm sorry, not to
9 interrupt, I just -- I am looking at that
10 clock.
11 But -- and I understand that, it kind
12 of goes into one of my other questions about
13 the DAB that you've been speaking about
14 already with regards to prescription drugs.
15 But would the administration commit to not
16 raising HCRA taxes or assessments on
17 healthcare bills as a means to closing the
18 Medicaid spending gap? That's one of the
19 things I'm concerned about. Are we going to
20 start dipping into increasing taxes, which
21 could increase premiums for people paying for
22 private health insurance right now?
23 SUPERINTENDENT LACEWELL: Right. So I
24 understand that you would obviously raise

1 that in your discussions with the Executive.
2 I am at DFS, and I am not in charge of taxes.
3 ASSEMBLYMAN BYRNE: Okay. Now, going
4 back to what you were speaking about a little
5 bit before with this creation of this new
6 Drug Accountability Board within the budget
7 proposal that's been mentioned already. And
8 you've kind of answered this a little bit,
9 but could you just elaborate a little bit
10 more? What are we doing right now? What
11 roles and responsibilities do we have right
12 now to help address this issue? And is this
13 a duplication of efforts?
14 I know you mentioned that you have a
15 relationship, obviously, with the Attorney
16 General's office and that there are multiple
17 agencies that have similar authorities and
18 powers. But is it necessary to create a
19 whole new board to accomplish the goal here,
20 or do we already have tools and laws in place
21 today that you could take advantage of to get
22 to -- to address the needs that we're trying
23 to address right here?
24 SUPERINTENDENT LACEWELL: Thank you,

1 Assemblyman.
2 I think the idea of the board is to
3 bring the experts together who are deeply
4 involved in understanding the pharmaceutical
5 industry, and in healthcare, so that you've
6 got the experts around the table who are in a
7 position to advise with respect to what may
8 be driving the cost spiking in prescription
9 drugs. I think it's similar to the Medicaid
10 Drug Utilization Review Board, which is a
11 similar concept where experts get together
12 and they're in a position to advise on the
13 appropriateness of the pricing of the drug.
14 ASSEMBLYMAN BYRNE: So could you just
15 explain again the difference between the
16 Attorney General's office powers and what you
17 would be looking for through DAB, as far as
18 if you found a company to be doing something
19 nefarious and you think they're price
20 gouging, if they're committing a crime, and
21 the Attorney General's office has powers to
22 act on that. So what would -- what's the
23 difference?
24 SUPERINTENDENT LACEWELL: By the way,

1 the Attorney General does not have
2 independent authority on the criminal side.
3 She would need a referral from a relevant
4 agency, and perhaps that would be us.
5 In other words, we can investigate and
6 we have the ability to refer it to her, under
7 the Executive Law, to provide her with
8 criminal authority if a crime may be
9 occurring.
10 ASSEMBLYMAN BYRNE: Okay, thank you.
11 I'm out of time.
12 CHAIRWOMAN WEINSTEIN: Thank you.
13 We go to Senator Little.
14 SENATOR LITTLE: Thank you,
15 Superintendent, for being here. You
16 certainly have a number of things in your
17 purview in your agency.
18 SUPERINTENDENT LACEWELL: Yes.
19 SENATOR LITTLE: But the one big
20 concern I have is the PBMs. And a lot of
21 questions have been asked about it, so I'm
22 not going to continue in that vein. But I
23 just want to stress how important it is that
24 something be done, because we are losing

1 independent pharmacies. It does affect the
2 chain pharmacies just as much, but they have
3 a bigger base to work with, and they're in
4 multiple states and not so -- you know, they
5 can cover each other. Whereas an independent
6 pharmacy has no way of staying alive.
7 We just lost one that had been in
8 existence for I think almost 75 years, and
9 they closed their doors in January, this past
10 month, so.
11 The problem -- and the Governor has
12 this listed, all the things that they want
13 you to do: To begin to license them, to
14 begin to have some oversight, to work on how
15 they're collecting. They raise the prices on
16 their drugs that the pharmacist has to pay,
17 and yet the insurance doesn't pay. They are
18 losing money by filling some prescriptions.
19 And, you know, no business can continue that
20 way.
21 And they definitely believe that there
22 is a conflict of interest here between some
23 of the PBMs and the health plans in
24 existence.

1 So I would just ask you to seriously
2 look into this. It says by 2022. Something
3 needs to be done faster than that, because
4 we're going to lose more and more.
5 You know, I have -- two of my biggest
6 areas are Glens Falls and Queensbury, a
7 population probably about 48,000, of my
8 district. Not one independent pharmacy left.
9 So I would just like to say that and
10 stress the importance of that.
11 SUPERINTENDENT LACEWELL: All right,
12 thank you, Senator. I will take that to
13 heart.
14 SENATOR LITTLE: Thank you.
15 ASSEMBLYMAN CAHILL: All done, Betty?
16 Thank you. Then we will move to Assemblyman
17 Félix Ortiz.
18 ASSEMBLYMAN ORTIZ: Thank you,
19 Mr. Chairman, thank you very much.
20 Thank you, Superintendent, and good
21 afternoon.
22 SUPERINTENDENT LACEWELL: Good
23 afternoon.
24 ASSEMBLYMAN ORTIZ: I do have a very

1 quick question. What does the state require
2 as a minimum standard for services in the
3 insurance plan?
4 SUPERINTENDENT LACEWELL: The minimum
5 standard?
6 ASSEMBLYMAN ORTIZ: Yes, ma'am.
7 SUPERINTENDENT LACEWELL: For
8 insurance?
9 ASSEMBLYMAN ORTIZ: Yes.
10 SUPERINTENDENT LACEWELL: I don't know
11 if I know exactly what you mean. But
12 obviously there a number of requirements
13 before one can be licensed to engage in the
14 business of insurance.
15 ASSEMBLYMAN ORTIZ: Just to clarify,
16 it's about the insurance company -- you know,
17 what is the minimum that they can offer if I
18 buy insurance for my family? Health
19 insurance.
20 SUPERINTENDENT LACEWELL: For health
21 insurance.
22 ASSEMBLYMAN ORTIZ: Yes, ma'am.
23 SUPERINTENDENT LACEWELL: Well, there
24 is a set of essential benefits that are in

1 law, and that's part of what we codified last
2 year with the Affordable Care Act, as to what
3 commercial health insurers have to include.
4 And I'm happy to come back and provide your
5 staff with that detailed list, or if there's
6 a more specific question you have in that
7 regard.
8 ASSEMBLYMAN ORTIZ: Let me just ask
9 you a few other questions regarding that.
10 The DFS, and I quote, according to your
11 testimony right here, the DFS, quote,
12 regulates more than 1400 insurance with
13 assets of more than $4.7 trillion, and I'm
14 going to close quotes there.
15 And I also see here that the Governor
16 is trying to do a wonderful thing about the
17 Mental Health Parity and Equity Act
18 compliances. I'm going to give you this
19 quick scenario, because I do have time, a
20 quick scenario.
21 I do have constituents in my district
22 who suffer from eating disorders. An eating
23 disorder is a very difficult -- and we can
24 call it a mental health disease or illness to

1 treat. One of the things that I find out
2 through my constituents is that when they go
3 through the treatments, health insurance
4 regularly do not cover enough for the
5 coverage.
6 One, what do the -- what your agency
7 can do to make sure that we be able to assist
8 these individuals who are -- have to pay out
9 of their pocket $5,000, $10,000 a month for
10 treatment.
11 Secondly, I find out that sometimes
12 the kids that suffer or the adults that
13 suffer from -- or the teenager that suffers
14 from an eating disorder, sometimes they need
15 one or two or three psychologists. And
16 because of the qualifications that they use,
17 they are already removed from the insurance
18 company to pay for those services. If you go
19 to a psychiatrist, also the same thing
20 happens.
21 So I'm bringing this to your attention
22 because I know that the Governor in his
23 wonderful State of the State and this paper
24 that I see here in my hands has a lot of

1 initiatives for increased coverage for
2 different areas. And I will be asking for a
3 big please on behalf of this community, that
4 if you do have the authority to look into it
5 these insurance companies and work with the
6 other entities or agencies who have the
7 authority as well, that we do what is right
8 for my people or my kids in my district
9 that's -- I'm asking the State of New York
10 because I was the guy who did the three
11 eating disorder centers, and the money's
12 gone, which is a shame, and they had to close
13 down and we don't have a real outpatient
14 clinic, in-service patient clinic in the
15 State of New York to take care of our kids.
16 And the parent has to spend their own
17 money, they have to sell their homes, their
18 stores, their businesses, whatever savings
19 they have, in order to take care of their
20 children. And I am a testimony of that with
21 my granddaughter.
22 So I ask you and I plead you to please
23 let's make these insurance companies
24 accountable, let's not make the insurance

1 company to continue to treat and make
2 decisions on behalf of our children, our
3 families, and to choose the treatment that
4 they need to get, because they want to be
5 part of the treatment of this disorder.
6 Thank you for hearing me and hearing
7 the people of my community. Thank you.
8 SUPERINTENDENT LACEWELL: Thank you.
9 And thank you for those remarks and for
10 sharing that story.
11 Obviously, eating disorders are part
12 of the larger issue of mental health, and
13 insurers are supposed to provide parity on
14 mental health and physical health in terms of
15 what they cover, and their networks are
16 supposed to be just as robust, and their
17 practices are supposed to be equivalent.
18 I believe that mental health is the
19 last frontier with respect to a major area of
20 health insurance that needs to be addressed.
21 Unfortunately, many people still view mental
22 health issues as bringing stigma, and people
23 are reluctant to step forward. When they
24 step forward, we should make sure that they

1 get the help that they need. And we should
2 make sure that if they're not willing to
3 speak up, that we're speaking up for them.
4 The mental health parity compliance
5 proposed regulations that are in the
6 Governor's proposal would go squarely to this
7 issue. And I've already had a number of deep
8 conversations with our staff about how we
9 address the problem of making sure that our
10 insurers comply with their responsibilities.
11 Just because you put a network
12 together and it's got three people in it but
13 they're not accepting new patients, that's
14 not adequate. I don't care what the
15 definition is of adequacy, it doesn't cut it,
16 as a regulator. And parity is real, and
17 mental health is just as vitally important as
18 physical health, and it's got to be treated
19 the same.
20 I think many of us have family and
21 close friends who have incurred issues.
22 Young people and others, eating disorders are
23 a very big problem. I think that there is a
24 significant date coming up for the advocates

1 in that field, and I believe there may be an
2 opportunity for a broader dialogue between
3 the Executive and the Legislature and the
4 advocacy community and the industry on this
5 point.
6 ASSEMBLYMAN ORTIZ: I do have
7 legislation on it, and I like to share with
8 you. Thank you.
9 CHAIRWOMAN WEINSTEIN: Thank you,
10 Assemblyman Ortiz.
11 We've been joined by Assemblywoman
12 Buttenschon and Assemblyman Steck.
13 And we now go to Assemblywoman Hunter
14 for a question.
15 ASSEMBLYWOMAN HUNTER: Thank you.
16 Superintendent, it's a pleasure to be
17 here today. I actually have the privilege of
18 being on the Insurance Committee and actually
19 sitting on the Opioid Task Force for the
20 Speaker, and so I bring questions to you from
21 those angles.
22 I wanted to -- two things, two
23 comments and then two questions.
24 One, wanted to voice with my

1 colleagues concerns relative to the veto
2 about the PBMs. I too have community
3 pharmacies in my district that it impacts.
4 And also wanted to voice my distress for the
5 veto for the continuing education bill. It
6 went around two times, and the first message
7 was relative to too many credits; the second
8 message was saying that this would set a
9 course for other, I guess, industries to
10 follow the same.
11 And I say that's great, especially
12 when these professional associations, you
13 have to spend many dollars in order to be a
14 part of them, and they're the perfect
15 examples and organizations to provide
16 professional conferences and curriculum.
17 But my two questions.
18 So we've been having many
19 conversations about prescription drug costs
20 and figuring about the pricing, how does the
21 pricing work. And I think that's a circular
22 question. I nationally have this
23 conversation about how drug costs come into
24 play, and I've basically had to go back to my

1 constituents and say they can increase it
2 because they can. And that's literally the
3 answer I was given from Pharma.
4 So as we're thinking about, you know,
5 how we reduce costs and increase fees -- and,
6 you know, I'm the last one -- and especially
7 in the district that I represent that is
8 diverse and has a high concentration of
9 poverty, there are two areas which it doesn't
10 seem have been addressed in the budget which
11 I think could be important.
12 One, and I don't necessarily think
13 people should be getting their health
14 information necessarily from Good Morning
15 America. But I do think that when you hear
16 about a national recall, and we're talking
17 about something like Ranitidine -- and I get
18 questions about this from my constituents --
19 who pays either the consumer back for their
20 insurance payment, the -- I guess the state
21 back -- the plans back for the portion that
22 they have paid, back to the manufacturer who
23 is selling these drugs that are
24 cancer-causing.

1 And I guess I would want to know the
2 question to that, because it seems like we're
3 spending a lot of money to find out that
4 drugs have been recalled because there's been
5 significant health risks, but people aren't
6 getting their money back.
7 And my second question would be
8 related to the opioid resettlement dollars.
9 And I don't know how much money has been
10 allocated to New York State, but I know that
11 there's a huge lawsuit and money is supposed
12 to be coming back, and wanting to know how we
13 plan on addressing that coming into New York
14 State. Obviously, you can't spend money you
15 don't have. But it seems to me, with the
16 high rate of deaths that we're having
17 relative to opioid use, we need to be doing
18 something different than we've been doing,
19 because the rates are increasing, they're not
20 decreasing.
21 So those two questions,
22 Ms. Superintendent. Thank you.
23 SUPERINTENDENT LACEWELL: And thank
24 you, Assemblywoman.

1 With respect to the opioid lawsuits
2 for New York, the lawsuit is being litigated
3 by the Attorney General. And my
4 understanding is negotiations, as has been
5 publicly reported, you know, continued apace.
6 And those are complex pieces of litigation
7 with multiple states and localities involved
8 in those.
9 For DFS, we initiated last fall, as we
10 publicly stated, an investigation with
11 respect on people who have commercial health
12 insurance whose rates have been increased
13 over time due to the overprescribing of
14 opioids and the need for the
15 addiction-related services, which generated a
16 lot of cost for commercial insurers. And as
17 you know, those get passed on to the
18 individual policyholders through rate
19 increases.
20 And so it isn't that the health
21 insurers are out of money, because in a sense
22 they've been reimbursed, it's as usual
23 consumers who have been left holding the bag.
24 And so what we have determined is

1 that, you know, in excess of a billion and
2 perhaps up to $2 billion over the past 10
3 years was passed on to New Yorkers in the
4 form of rate increases due to the opioid
5 crisis and that scandal and the
6 overprescribing and the need for the
7 addiction services.
8 And so we are -- we have a very
9 intensive investigation that is geared at
10 trying to get back some of that money for the
11 money for the benefit of the consumers.
12 Your question -- your first question I
13 think is sort of a related thought, which is
14 when there is some kind of wrongdoing or
15 scandal or inappropriateness, who then is
16 looking out for the consumer who is
17 out-of-pocket, and how do we get that money
18 back to that person?
19 And so we'll take a close look at that
20 on the question of recalls, because I'm less
21 familiar with how that works. But, you know,
22 I'm happy to work with you on that and think
23 that through. And if we can do something
24 about it appropriately, then we'll do so.

1 CHAIRWOMAN WEINSTEIN: Thank you.
2 We go to Assemblyman Salka.
3 ASSEMBLYMAN SALKA: Thank you, Madam
4 Chairwoman.
5 And thank you, Superintendent. Thank
6 you for the work that you do.
7 I've got a little problem with this
8 3 percent surcharge on Certificate of Needs,
9 applications for Certificate of Needs.
10 From what I understand, the figure of
11 around 70 million is going to be generated.
12 An I correct in that? I heard that this
13 morning. Do you -- are you familiar with
14 that figure?
15 SUPERINTENDENT LACEWELL: I don't know
16 the number, but that may be right.
17 ASSEMBLYMAN SALKA: Okay. I was just
18 wondering, I mean -- well, some technical
19 questions about how those surcharges are
20 calculated. Is it the size of the project?
21 Or am I asking the wrong person this
22 question?
23 SUPERINTENDENT LACEWELL: Well, if I
24 understand what you're saying, I don't know

1 that it's a question for DFS. I think this
2 is DOH and Medicaid and the Division of the
3 Budget. If I can be helpful in facilitating
4 the conversation, I'm happy to do so.
5 ASSEMBLYMAN SALKA: Oh, good. Okay.
6 All right. Yeah, basically, I want to know
7 where the money is going to come from.
8 You can't charge it against Medicaid,
9 so obviously when you're applying for a
10 Certificate of Need, the money's got to come
11 from somewhere and it's going to have to be
12 passed along to somebody. And it seems to me
13 like it might just end up increasing costs
14 that eventually trickle down to the patient.
15 SUPERINTENDENT LACEWELL: Yeah. Well,
16 I think that Certificates of Need are within
17 the purview of the Department of Health. But
18 our staff will work with yours to make sure
19 you get the information you need.
20 ASSEMBLYMAN SALKA: All right, thank
21 you.
22 CHAIRWOMAN WEINSTEIN: Assemblyman
23 Cahill.
24 ASSEMBLYMAN CAHILL: Thank you,

1 Madam Chair.
2 Superintendent, a couple of follow-up
3 questions to things that we've discussed
4 already. The first one is whether the
5 Attorney General has registered in one way or
6 the other on your proposal for the additional
7 powers that you described as filling the gap
8 where DFS lags far behind the federal
9 government and other states.
10 SUPERINTENDENT LACEWELL: I have no
11 reason to believe that she opposes that
12 proposal. Obviously, you can speak with her.
13 But I have received no information that she
14 is concerned about that proposal. As I said,
15 we have a very good working relationship.
16 And the view of those typically who
17 enforce the law is that there's a lot of work
18 out there to be done and we need multiple
19 players to get the work done to protect
20 New Yorkers.
21 ASSEMBLYMAN CAHILL: So that's half of
22 the answer.
23 Did the Attorney General indicate that
24 she supported your proposal?

1 SUPERINTENDENT LACEWELL: I have not
2 spoken with the Attorney General about the
3 proposal. I'm not familiar with her weighing
4 in one way or the other.
5 ASSEMBLYMAN CAHILL: I want to go to
6 the surprise billing modifications that the
7 Governor is proposing in the budget and talk
8 about the concept of provisional
9 credentialing.
10 Can you please explain how provisional
11 credentialing is supposed to work from a
12 quality and systematic billing point of view,
13 if somebody is provisionally credentialed?
14 SUPERINTENDENT LACEWELL: You'll have
15 to give me more of a context. Provisional
16 credentialing of what? I'm not familiar with
17 that issue.
18 ASSEMBLYMAN CAHILL: Well, in the
19 Governor's reform under surprise billing,
20 he's indicated that they will require
21 insurance companies to provisionally
22 credential providers. My question is, how
23 would that actually work mechanically?
24 SUPERINTENDENT LACEWELL: Oh, I see.

1 I'll have to get back to you on the mechanics
2 of it.
3 ASSEMBLYMAN CAHILL: Okay, thanks.
4 Earlier I asked you about CVS
5 Caremark's position with regard to the
6 Governor's proposal on regulating PBM, and
7 you indicated -- I asked you if they
8 indicated support for the legislation, and
9 you said they did.
10 I guess my question to you is, how did
11 you become aware of that? Is that something
12 that has been communicated to your office by
13 CVS Caremark?
14 SUPERINTENDENT LACEWELL: Thank you
15 for the question.
16 I believe that their agreement not to
17 oppose regulation is in the public record,
18 both through the press release from DFS
19 approving the merger through Troy Oechsner's
20 testimony last year in the Budget Committee,
21 and otherwise reported in the press.
22 ASSEMBLYMAN CAHILL: So you're --
23 you're -- and I will ask you the question.
24 Are you referring to that which was discussed

1 by DFS in October of 2018, which would have
2 been prior to your tenure, prior to the
3 Governor's veto, and prior to this current
4 proposal?
5 SUPERINTENDENT LACEWELL: Mr. Oechsner
6 testified before this committee within days
7 of me taking office at DFS, so he did the
8 budget testimony. I was at DFS at the time.
9 And I have reviewed his testimony, and I
10 watched the video recording where he
11 testified before this committee and read his
12 remarks, and there are also written remarks,
13 that CVS had agreed not to oppose regulation.
14 ASSEMBLYMAN CAHILL: So again, my
15 question is pertaining to the very proposal
16 before us right now in the 2020 budget
17 proposal by the Governor. And my question to
18 you was whether CVS indicated that they would
19 support or oppose this. Your answer to me
20 was that they were going to support it.
21 I'm now asking you specifically, have
22 they addressed the 2020 proposal -- not
23 Mr. Oechsner's testimony which was offered
24 last year before this proposal was made, not

1 in October of 2018 when CVS Caremark was
2 laying down the conditions for their
3 acquisition or the merger with Aetna
4 Insurance Company, but this very proposal?
5 Has there been any communication to
6 you or, to your knowledge, with the
7 Governor's office on this specific proposal
8 from CVS Caremark?
9 SUPERINTENDENT LACEWELL: I don't have
10 specific information about any such
11 conversations. I certainly haven't had those
12 conversations.
13 I am generally aware that over the
14 course of time, those who have been working
15 on proposals to be presented have indicated
16 that the larger PBMs understand that
17 regulation is coming and they're expecting
18 that, and that they're not standing in the
19 way of that.
20 What their position is on a particular
21 bill or a version of a bill, I couldn't say.
22 I would be very surprised indeed if CVS now
23 reversed its position and said "We're opposed
24 to being regulated," when in fact it was an

1 express condition of DFS approval of the
2 merger.
3 ASSEMBLYMAN CAHILL: All right. Thank
4 you very much.
5 CHAIRWOMAN WEINSTEIN: Thank you.
6 Superintendent, I have just one quick
7 question, really a follow-up to some of the
8 discussion that people have raised about the
9 Drug Accountability Board.
10 How will DFS ensure that there's no
11 conflict of interest between members of the
12 Drug Accountability Board, pharmaceutical
13 companies, while still ensuring that members
14 of the board will have sufficient expertise
15 to perform their duties?
16 SUPERINTENDENT LACEWELL: So that's a
17 good question. And that is the perennial
18 problem, of course, because you want
19 stakeholders from an industry as a whole, if
20 you're going to get the complete picture of
21 representation.
22 So I understand your point about
23 conflicts of interest, and I'll go back
24 through the bill which indicates what the

1 composition ought to be. And of course it
2 includes the Department of Health, which is a
3 very important component in terms of
4 generating neutrality and integrity of those
5 deliberations.
6 CHAIRWOMAN WEINSTEIN: Well, thank you
7 for that response, and also for your being
8 here today.
9 CHAIRWOMAN KRUEGER: Yes, thank you
10 very much. I was just right there.
11 SUPERINTENDENT LACEWELL: Thank you.
12 CHAIRWOMAN WEINSTEIN: So I think that
13 concludes the questions from both the Senate
14 and the Assembly. Thank you.
15 SUPERINTENDENT LACEWELL: Thank you
16 very much.
17 CHAIRWOMAN KRUEGER: Thank you.
18 Appreciate it.
19 And for those following, we're still
20 on page 1. And we have Dennis Rosen,
21 Inspector General, the New York State Office
22 of Medicaid Inspector General. And he's been
23 here before with us. Actually, I saw him
24 here all day. So if he wants to answer DOH

1 or DFS questions, maybe he'll be ready to do
2 that also.
3 INSPECTOR GENERAL ROSEN: Good
4 afternoon.
5 CHAIRWOMAN KRUEGER: Hi. Whenever
6 you're ready.
7 INSPECTOR GENERAL ROSEN: Okay. Good
8 afternoon, everyone. As you have my full
9 testimony before you, I will provide a brief
10 summary and be happy to answer any questions.
11 OMIG's comprehensive investigative and
12 auditing efforts, extensive partnerships with
13 law enforcement agencies and collaborative
14 work with agencies and stakeholders across
15 the state are projected to deliver more than
16 $2.8 billion in cost savings and Medicaid
17 recoveries in calendar year 2019.
18 Preliminary 2019 figures indicate the
19 agency's proactive cost avoidance measures,
20 which prevent, up front, inappropriate
21 Medicaid payments, generated estimated
22 savings of more than $2.3 billion. OMIG
23 recoveries, including audits, third-party
24 liability and investigations, total more than

1 $542 million.
2 In addition, OMIG had many successful
3 collaborations with law enforcement. For
4 example, OMIG played a key role in a 2019
5 joint investigation with the Attorney
6 General's Medicaid Fraud Control Unit,
7 New York State Department of Health, and
8 United States Department of Health and Human
9 Services Office of the Inspector General. It
10 led to the arrests of a New York City
11 pharmacy owner and three of her managers for
12 their alleged participation in a $10 million
13 Medicaid fraud scheme involving kickbacks and
14 HIV prescription drug diversion.
15 The defendants filed thousands of
16 false claims for reimbursement from Medicaid
17 and Medicaid managed care organizations for
18 refills that were not dispensed, an illegal
19 practice known as auto refilling. The
20 maximum state prison sentence for these
21 offenses is 25 years.
22 Also in 2019 OMIG continued its vital
23 work with its partners to address the opioid
24 crisis. The agency's recipient restriction

1 program is a key tool in this effort. It
2 helps prevent the filing of duplicate
3 prescriptions through doctor or pharmacy
4 shopping by restricting patients suspected of
5 overuse or abuse to a single designated
6 healthcare provider and pharmacy.
7 Preliminary 2019 data show 1,767 of
8 the 1,992 Medicaid recipients reviewed were
9 recommended for restriction to the
10 appropriate Medicaid managed care plan,
11 county agency, or New York State of Health.
12 As a result, more than $85 million in costs
13 to the Medicaid program were avoided, and
14 quite likely many lives were saved.
15 The agency's 2019 preliminary
16 enforcement statistics show strong results.
17 OMIG opened more than 2,800 investigations,
18 completed over 2,700 investigations, and
19 referred more than 800 cases to
20 law enforcement and other federal, state and
21 local agencies. Additionally, OMIG issued
22 more than 700 Medicaid exclusions.
23 Exclusions are a powerful program integrity
24 tool, and an excluded provider is prohibited

1 from participating in New York's Medicaid
2 program and any other state's program.
3 OMIG continues to focus on and
4 implement new initiatives related to program
5 integrity within the managed care arena.
6 Efforts include performing various
7 match-based audits and utilizing data mining
8 and analyses to uncover trends or patterns
9 that identify future reviews. Audits result
10 in the recovery of inappropriate premium
11 payments and identify actions to address
12 systemic and/or programmatic issues.
13 Preliminary data for 2019 indicate these
14 efforts resulted in 483 finalized audits,
15 with more than $177 million in recoveries.
16 OMIG also continues to review managed
17 care plans' Provider Investigative Reports,
18 which started just a couple of years ago,
19 which plans are contractually obligated to
20 submit to OMIG and DOH quarterly. The report
21 provides valuable information, including
22 MCOs' provider investigative activities and
23 disclosures of any MCO settlement agreements
24 with network providers.

1 Through legislation enacted in 2019,
2 OMIG acquired a very significant additional
3 managed care program integrity tool. OMIG is
4 authorized to conduct annual reviews of all
5 MCOs and MLTCs to assess their compliance
6 with contractual standards that prevent
7 fraud, waste or abuse, such as jettisoning
8 from their networks providers that have been
9 excluded from the Medicaid program at the
10 federal or state level, utilizing effective
11 recipient restriction programs, complying
12 with various reporting obligations,
13 maintaining adequate compliance programs, and
14 suspending provider payments when
15 appropriate.
16 Implementing statewide this critical
17 program integrity review initiative has been
18 a major OMIG focus, and I'm proud to report
19 on our progress today. Comprehensive reviews
20 of each of New York's 15 mainstream MCOs are
21 well underway. Year 2 of the effort will
22 include, in addition to the mainstream plans,
23 reviews of MLTCs.
24 Also last year, OMIG continued to

1 provide extensive provider outreach and
2 education -- through educational webinars,
3 guidance materials, presentations and on-site
4 meetings -- to associations, provider groups
5 and other stakeholders across the state.
6 OMIG's website has been enhanced to
7 better serve the provider community and the
8 public, and the agency maintains an email
9 listserv with more than 5,100 subscribers.
10 Finally, OMIG currently posts 42
11 fee-for-service audit protocols on its
12 website, which continue to apprise the
13 healthcare industry of what OMIG looks for
14 when we conduct an audit.
15 OMIG's comprehensive Medicaid program
16 integrity efforts are a critical part of New
17 York's healthcare delivery system. My office
18 looks forward to playing an integral role in
19 the MRT initiative and will continue to
20 devote resources to strengthen program
21 integrity and efficiency, thereby ensuring
22 that the most vulnerable New York dollars --
23 I'm sorry, the most vulnerable New York
24 taxpayers and recipients -- taxpayers save

1 their money, and recipients receive the
2 high-quality care that they deserve.
3 Sorry, I think sitting here may have
4 affected my ability to read this well for
5 you.
6 Thank you. I'd be pleased to address
7 any questions you may have.
8 CHAIRWOMAN KRUEGER: Thank you.
9 Senator Gustavo Rivera.
10 SENATOR RIVERA: Thank you, ma'am.
11 I know we've had some issues in the
12 past. Can you hear me all right?
13 CHAIRWOMAN KRUEGER: Yes.
14 INSPECTOR GENERAL ROSEN: Yes.
15 SENATOR RIVERA: Just say -- can you
16 hear me?
17 INSPECTOR GENERAL ROSEN: Yes.
18 SENATOR RIVERA: Very well.
19 INSPECTOR GENERAL ROSEN: I can hear
20 you. Just please speak up, because sometimes
21 I had had issues.
22 SENATOR RIVERA: Yes. This is why I
23 want to make sure that -- it will be just one
24 question. It relates to the role and the

1 scope of the work that OMIG does, in
2 reference to some of the concerns that the
3 proposal in front of us, to try to fix
4 Medicaid, seems to want to address. And
5 particularly when you're talking about
6 determining eligibility -- the counties'
7 responsibility in determining eligibility for
8 Medicaid patients.
9 There is a proposal that obviously
10 doesn't cover your office, right, there is a
11 proposal -- are you familiar with the
12 proposal that is currently being considered?
13 INSPECTOR GENERAL ROSEN: We really
14 have no role to play with the initial
15 determinations as to eligibility. And so
16 we're not particularly familiar with the --
17 that side of program.
18 SENATOR RIVERA: So you don't have an
19 auditing or overseeing responsibility as
20 relates to counties and their -- in their
21 determination of eligibility?
22 INSPECTOR GENERAL ROSEN: Not with
23 respect to the initial determination. We
24 work very well with the counties on other

1 levels post-determination.
2 We have a recipient fraud program
3 where we cooperatively work with the counties
4 to root out recipient fraud; very often those
5 may result in referrals to law enforcement.
6 We do secondary audits. Once somebody is in
7 the programs, we do audits to see, for
8 example, that in managed care the person is
9 in the program, they haven't left the state,
10 they haven't passed away, issues like that.
11 And in fact those audits have resulted in --
12 last year have resulted in about $54 million.
13 But the initial determination of
14 eligibility is a DOH and a county issue.
15 SENATOR RIVERA: Okay. So you don't
16 have -- you not having any role in looking
17 into that -- because there seems -- and you
18 might not be able to answer this question,
19 but there have been the -- what we have heard
20 from either the Governor or the Medicaid
21 Director or the Department of Health related
22 to counties' actions or not. They suggest
23 that some counties are doing something wrong,
24 and when that's brought up and the question

1 is asked specifically "So you're saying that
2 counties are doing something wrong?" "Oh,
3 no, no, no, we're not saying that, but" --
4 and it just seems to go into this circle.
5 And so I just was trying to understand
6 the role of OMIG as it relates to what the
7 counties do originally as far the
8 determination of eligibility, which is what
9 the proposal seems to want to address, you
10 have nothing to do with that?
11 INSPECTOR GENERAL ROSEN: Yeah. And
12 in fact, again, I think in many areas we've
13 worked very well with the counties,
14 particularly the expanding transportation
15 area. And I would like to take this
16 opportunity, frankly, to put the word out
17 that we'd ask counties to consider enrolling
18 in our county demo project, demonstration
19 program.
20 There is opportunity there for
21 counties to make recoveries with our
22 collaboration. They can keep some of the
23 money that's recovered. And I know in the
24 past there have been problems, but we've

1 really invested considerable resources in
2 enhancing that program and better
3 communications with the counties.
4 SENATOR RIVERA: So you -- okay. I
5 mean, I think that it's pretty well
6 established that the work that you do is at
7 the back end, not the front end, so to speak.
8 So what we're trying -- what this is
9 supposedly trying to fix is the front end,
10 meaning when the determination of eligibility
11 is made, as opposed to the back end, which is
12 what you have a role in auditing and making
13 sure that everything is copacetic. Correct?
14 INSPECTOR GENERAL ROSEN: Yes.
15 SENATOR RIVERA: All right. Thank you
16 so much.
17 CHAIRWOMAN KRUEGER: Thank you.
18 CHAIRWOMAN WEINSTEIN: Assemblyman
19 Abinanti.
20 ASSEMBLYMAN ABINANTI: Thank you,
21 Madam Chair.
22 Thank you -- is it -- am I supposed to
23 call you "Inspector" or "General"?
24 INSPECTOR GENERAL ROSEN: Dennis is

1 fine.
2 (Laughter.)
3 ASSEMBLYMAN ABINANTI: Okay, I'm Tom.
4 Thank you for your presentation. I'd
5 like to go to the last point that you made.
6 You were talking about the OMIG's
7 responsibility for program integrity. I
8 understand you've done a pretty good job at
9 preventing fraud and waste and catching fraud
10 and waste. But doesn't that also include
11 making sure that they provide the services
12 that their contract says they're supposed to
13 provide?
14 INSPECTOR GENERAL ROSEN: We do do
15 audits that touch on that very -- actually,
16 very significantly. So, for example,
17 we'll -- we don't get involved in individual
18 litigation over whether or not a service
19 should be provided or those kinds of
20 administrative --
21 ASSEMBLYMAN ABINANTI: Well, no, let
22 me go right to the point here.
23 INSPECTOR GENERAL ROSEN: But what we
24 do do is we'll look at billing and we'll see

1 to it that the services were properly
2 provided that are claimed in the billing.
3 ASSEMBLYMAN ABINANTI: Okay, but do
4 you look at contracts? Here's my point. The
5 previous witness admitted that the number of
6 physical therapists and occupational
7 therapists and speech language pathologists
8 in the insurer's networks have been found to
9 be low. She also admitted that they have
10 found that insurers do not have adequate
11 policies and procedures in place for
12 compliance with the mental health parity law.
13 Now, these seem to me to be violations
14 of the contracts that these entities have
15 with the state. Do you do any compliance
16 review to make sure that these places are not
17 being paid for individuals who are part of a
18 managed care plan, let's say, and yet the
19 plans don't offer the services that they said
20 to the state they were going to offer?
21 Now, an individual will sign up for an
22 individual plan and they'll say, Oh, great, I
23 can get all of these services. They get
24 there and they find out, well, you know what,

1 there are no therapists available, the few
2 that are on the list are now booked solid.
3 And to me that's a fraud on the state and on
4 the individuals to misrepresentation as to
5 what they were going to offer.
6 Do you look at that at all?
7 INSPECTOR GENERAL ROSEN: If
8 somebody's not receiving the services they're
9 supposed to get, we definitely will look at
10 that. We look at compliance programs --
11 although that's more toward internal control
12 sorts of things. But that's a part of the
13 internal control reviews.
14 Generally what we don't get into is --
15 and again, this is more administrative
16 proceedings that have nothing to do with
17 us -- situations where there's a disagreement
18 over whether or not a medical service is
19 necessary or should be provided.
20 ASSEMBLYWOMAN ABINANTI: No, no, I'm
21 not saying that. What I'm saying is somebody
22 joins a managed care plan because there's a
23 whole panoply of services, and then they
24 become part of the plan and the services

1 aren't there. Do you look at that?
2 INSPECTOR GENERAL ROSEN: That is
3 something we would look at.
4 ASSEMBLYMAN ABINANTI: Have you done
5 any reports on your reviews of those?
6 INSPECTOR GENERAL ROSEN: We've done
7 audits that talk about services not being
8 provided even though there's billing for the
9 services. But we haven't -- we don't focus
10 on you have to give this person this service.
11 ASSEMBLYMAN ABINANTI: No, no, not on
12 the individual service.
13 INSPECTOR GENERAL ROSEN: That has not
14 been our focus.
15 ASSEMBLYMAN ABINANTI: I'm talking
16 about actually being available, you know.
17 Because I've heard the reports of people
18 saying I'm part of a managed care plan, I go
19 to ask for this service, there's nobody
20 available.
21 So it seems to me that's a
22 misrepresentation, and your predecessor in
23 that seat admits that there aren't enough
24 therapists, et cetera, et cetera, in these

1 plans.
2 So who is in charge, in this
3 government, with looking at the contract
4 compliance -- when an entity gets a contract
5 for being a managed care plan in the State of
6 New York, who is charged with making sure
7 that they actually have available to people
8 the services that they say they have? I'm
9 not talking about individual people, whether
10 they get them or not, I'm talking about
11 they're just not available. Who's looking at
12 that for the State of New York?
13 INSPECTOR GENERAL ROSEN: If we
14 received a specific complaint that a service
15 should be available and was not available,
16 that was something we would act on.
17 We don't do general complaints -- we
18 don't do general reviews to see how many
19 different kinds of professionals, for
20 example, are working for a managed care plan.
21 ASSEMBLYMAN ABINANTI: Well, how do we
22 get you to do that?
23 INSPECTOR GENERAL ROSEN: We would
24 investigate an individual complaint. The

1 more general issues with respect to staffing
2 we see as more a DOH area.
3 ASSEMBLYMAN ABINANTI: I would just
4 like to ask that in the future you look a
5 little bit more towards the substantive
6 contract compliance, because we're relying on
7 these entities and we're paying these
8 entities to be available and to provide
9 services. And if not they're there, as the
10 previous witness said they're not there, then
11 the State of New York is being defrauded and
12 the people are not getting services.
13 INSPECTOR GENERAL ROSEN: No, there
14 would be an issue that we would look at,
15 because there's a capitation payment being
16 paid for that enrollee, for that recipient.
17 ASSEMBLYMAN ABINANTI: Exactly.
18 INSPECTOR GENERAL ROSEN: And if
19 they're not receiving the service, that is an
20 issue that we can look at.
21 And again, we have looked at issues
22 where there's billings and you haven't
23 received the services.
24 CHAIRWOMAN WEINSTEIN: Thank -- thank

1 you. Senate?
2 CHAIRWOMAN KRUEGER: Thank you.
3 Senator James Seward.
4 SENATOR SEWARD: Thank you.
5 Mr. Rosen, I notice that the Executive
6 proposes 69 FTEs, additional FTEs for your
7 unit. And could you describe for us just
8 what these 69 new FTEs will be doing?
9 INSPECTOR GENERAL ROSEN: This is
10 something that --
11 SENATOR SEWARD: And the need for
12 them?
13 INSPECTOR GENERAL ROSEN: I'm sorry,
14 this is something that is very recent, by the
15 way. And I can't give you a breakdown of
16 what every one of the 69 people would be
17 doing, because we're discussing various
18 initiatives right now. And we'll be
19 consulting with DOH on that further also.
20 I can tell you generally that I think
21 it's a recognition of the work we've been
22 doing -- for example, the $2.8 billion that
23 the program got last year because of our cost
24 avoidance and recovery efforts, and the

1 understanding that if we're given more
2 resources we can accomplish more, and I'm
3 absolutely confident that we can.
4 One area that we'll be doing a lot in,
5 we'll actually be putting together a specific
6 unit that involves managed care. And earlier
7 in my testimony I talked about the statute
8 that was passed last year, and in fact I
9 frankly want to take this opportunity to
10 thank you for enacting that statute, because
11 I think it really is going to make a huge
12 difference in terms of seeing to it that the
13 managed care industry is efficient and
14 compliant with the rules of the Medicaid
15 program.
16 And under the reviews now that we've
17 started to conduct under the legislation that
18 was passed last year, we're looking very
19 closely at their compliance with their
20 contractual obligations, and those are set
21 forth very, very clearly in the statute. We
22 talk about it on our website. We're looking
23 at things like do you have a adequate
24 recipient restriction program. Do you --

1 have you jettisoned from your provider
2 network providers who have been excluded from
3 the Medicaid program, either at the federal
4 or state level? We look at things like that,
5 and we're going to be grading them. And
6 based on the grade that they get for
7 compliance with the obligations that they
8 have signed a contract with respect to, we'll
9 determine whether or not there's a recovery
10 to be made.
11 So that that is an area where we'll be
12 putting together a specific unit that will
13 focus very much on managed care. Now it's
14 more divided throughout the agency and
15 different functions.
16 Another area where we've been trying
17 to enhance our efforts -- and this will be a
18 great help with respect to that -- is doing
19 more with data: Data analysis, data mining,
20 having access to different kinds of data.
21 Because that's really, today, where the
22 healthcare industry and the regulation
23 therefore is headed.
24 So those are some of the areas. But

1 what we also do, so people can keep track of
2 our efforts and where we're focusing, is we
3 on our website post our work plan. It comes
4 out in April, but we actually constantly
5 update it throughout the course of the year.
6 And as program focuses and emphases develop,
7 we'll be modifying the work plan so people
8 will be able to keep track of where we're
9 focusing.
10 SENATOR SEWARD: Thank you for your
11 answer. I had a couple of other questions I
12 wanted to get to.
13 What is your reaction to the recent
14 revelation from the State Comptroller, their
15 audits at the State Comptroller's office,
16 that Medicaid improperly reimbursed
17 $700 million? That's a big number.
18 INSPECTOR GENERAL ROSEN: The -- the
19 audits -- we're very familiar with those
20 audits. We work very closely and
21 collaboratively with OSC. Those audits cover
22 about a three-or-four-year period, and they
23 involve different areas.
24 Some of the areas that they involve

1 we're not involved with. For example,
2 Medicare Plan B was one of the focuses of one
3 of the audits that they referred to, and we
4 have nothing to do with that.
5 There are a couple of areas that we
6 are active in, and with respect to those
7 areas, we had ongoing audits at the time that
8 OSC started looking at it. We reviewed their
9 findings, we acted on them. So there was
10 nothing particularly surprising about their
11 audits, and I think we have a good
12 collaborative relationship with them.
13 But again, I want to emphasize that
14 this was over a period of years. This wasn't
15 something that just happened yesterday.
16 SENATOR SEWARD: One quick question.
17 Does your agency have a recovery target for
18 this year? Do you go for targets?
19 INSPECTOR GENERAL ROSEN: The recovery
20 target is still under discussion because,
21 again, the proposal to increase our FTEs is
22 relatively recent, and so we're still talking
23 about that.
24 SENATOR SEWARD: Thank you.

1 CHAIRWOMAN KRUEGER: Thank you.
2 Assembly.
3 CHAIRWOMAN WEINSTEIN: Thank you.
4 Assemblyman Byrne.
5 ASSEMBLYMAN BYRNE: Thank you.
6 And thank you, Inspector General,
7 we'll go by that. Or Dennis, is that the
8 right name? Thank you for being here today
9 and your patience.
10 Just to kind of follow up on what you
11 were just saying, it was going to be one of
12 my questions, referencing the press releases
13 from the State Comptroller's office over the
14 past -- not just this very recently, but the
15 past several years. It does seem that waste,
16 fraud and abuse becomes a bit of a political
17 cliche, but we know it does exist. And
18 after hearing your testimony and reading it,
19 it's encouraging to see that there is a lot
20 of good headway that is being made.
21 But I was hoping you could go into a
22 little bit more --
23 INSPECTOR GENERAL ROSEN: Could you
24 speak up more into the microphone, please?

1 I'm sorry, but I have trouble hearing --
2 ASSEMBLYMAN BYRNE: No, no problem,
3 sir. Is that better?
4 INSPECTOR GENERAL ROSEN: That's much
5 better.
6 ASSEMBLYMAN BYRNE: Okay. To follow
7 up on what Senator Seward was just speaking
8 about regarding the State Comptroller's
9 office report, it was something I was going
10 to ask as well because it's something that it
11 becomes cyclical. It's like every year
12 there's a release, and this one was very
13 recent, $800 million.
14 And it's encouraging to know that your
15 office does collaborate with the State
16 Comptroller's office. I was going to ask if
17 you could elaborate a little bit more on
18 that.
19 And also it's encouraging that while
20 it becomes a little bit of a political cliche
21 when we talk about waste, fraud and abuse in
22 a state program, that we're actually finding
23 it and are doing something about it. I just
24 feel like we should be able to do more.

1 My question is, first, if you could
2 elaborate on how you collaborate with the
3 Comptroller's office. Two, if the numbers
4 that you put in your testimony, if there's
5 any overlap with the savings that the
6 Comptroller's office has identified.
7 And something that's been talked about
8 when we were speaking about the Medicaid
9 Redesign Team and the cause for the
10 increasing costs in Medicaid -- have you
11 identified any examples of waste or fraud in
12 things like the Consumer Directed Assistance
13 Program or anything like that? If you could
14 just explain that a little bit, I would
15 appreciate it.
16 INSPECTOR GENERAL ROSEN: Okay.
17 The -- well, to take it one at a time, we do
18 work very closely with OSC. We have people
19 who regularly communicate with them, review
20 their audits, discuss -- they often ask us
21 how we do things, and that impacts how they
22 do things.
23 Very often their audits do have
24 suggestions that we think are very helpful

1 and we might follow through on those
2 suggestions. And again, often the work does
3 overlap. We very often -- again, as I said
4 earlier, when they start an audit, we've
5 already been involved in that area, so it
6 ends up collaborative and a partnership.
7 With respect to -- what else -- what
8 would you like me to answer next? You asked
9 two more.
10 ASSEMBLYMAN BYRNE: The numbers you
11 cited in your testimony about the --
12 INSPECTOR GENERAL ROSEN: The
13 recoveries, the 2.8?
14 ASSEMBLYMAN BYRNE: Correct. Does
15 that include anything that the Comptroller
16 released?
17 INSPECTOR GENERAL ROSEN: That does
18 not include the Comptroller's efforts.
19 But what happens is we go out and
20 we'll usually follow up on the audits and
21 we'll make the recoveries and yeah, to that
22 extent it does include it.
23 When they come out with a report, they
24 say "We think we've found something here,"

1 but it's always us who does follow up. So
2 yes, in that sense it does include their
3 numbers. But we're doing the work. We do
4 the follow-up. Compared to what we do,
5 theirs is a much more limited look, and then
6 we follow up.
7 ASSEMBLYMAN BYRNE: Yes. And then
8 thirdly, I was just curious, I know they
9 do -- it's a -- they do great work for a lot
10 of people, but have you identified any waste
11 or fraud specifically within the CDPAP
12 program at all?
13 INSPECTOR GENERAL ROSEN: There --
14 there's -- there are -- I mean, the program,
15 as you know, is so huge, there are going to
16 be problems throughout different areas of the
17 program. And yes, there have been problems
18 with consumer directed programs. In fact,
19 the federal government has pointed that out
20 from time to time. Health and Human
21 Resources' Office of the Inspector General
22 has issued a couple of reports regarding
23 consumer-directed healthcare.
24 And we get complaints on it; we also

1 do audits on it. We do regular audits on it,
2 and we've had recoveries. And so that's one
3 of lots of areas where there are issues.
4 ASSEMBLYMAN BYRNE: Great. Thank you,
5 sir.
6 CHAIRWOMAN KRUEGER: Thank you.
7 Senator Gallivan.
8 SENATOR GALLIVAN: Thank you. Can you
9 hear me okay?
10 INSPECTOR GENERAL ROSEN: Yeah, if you
11 get a little closer. Sorry, but the echo is
12 loud.
13 SENATOR GALLIVAN: The Consumer
14 Directed Personal Care Program, what do you
15 do in that particular area to ensure the
16 fiscal integrity of the program?
17 INSPECTOR GENERAL ROSEN: We will
18 audit to see if services were actually
19 provided to somebody, for example. We will
20 audit to see if the provider might be the
21 actual individual providing the services --
22 the aide, for example, might be billing --
23 doing duplicate billings, filing, in effect,
24 for being in two places at the same time with

1 two different recipients. Sometimes there
2 are quality of care issues that may arise,
3 which we may see as more of a law enforcement
4 issue, maybe our investigators will talk with
5 law enforcement about that.
6 And obviously, because -- I mean, it's
7 a very laudable program, you've got people
8 taking care of people that they know very
9 well, sometimes they're relatives, but
10 obviously that can also lead to issues that
11 may go to the heart of program integrity
12 where you've got people who are related and
13 it's federal money that's being spent.
14 So those are the kinds of issues that
15 arise with respect to consumer-directed care.
16 SENATOR GALLIVAN: So the program has
17 grown substantially over the past several
18 years. Have you been able to keep up with
19 it?
20 INSPECTOR GENERAL ROSEN: Yes. Yes.
21 Particularly, again, as has been referenced
22 in some other statements, with the aging
23 population in particular, you know, the home
24 care is a way to keep people out of

1 institutions.

2 SENATOR GALLIVAN: You have enough

3 people, you have enough policies in place,

4 you have enough tools to be able to keep up

5 with that particular program?

6 INSPECTOR GENERAL ROSEN: Well, we're

7 frankly very excited about the proposal to

8 increase our staffing, because we are very,

9 very confident, and I think our record bears

10 this out, that we will make very good use of

11 those added staff, and that will increase our

12 recoveries and it will, again, increase

13 overall I think the efficiency of the

14 program.

15 We've emphasized more cost savings

16 than we have in the past -- and those are

17 real, by the way. For example, a large

18 portion of the cost savings is where we find

19 an insurer who should be paying a claim

20 rather than somebody going to Medicaid. So

21 that we can show anybody who asks that our

22 cost avoidance numbers are very, very

23 reliable. And that's been an added emphasis

24 for us.

1 And again, as I mentioned earlier,
2 we're using more and more data to get to the
3 information that we need, because there's a
4 treasure trove of information that's
5 collected with respect to Medicaid.
6 So I do think that the addition of the
7 FTEs that we should be getting this year will
8 help us immeasurably. And again, I think our
9 past record shows that we use our resources
10 well.
11 SENATOR GALLIVAN: Thank you.
12 INSPECTOR GENERAL ROSEN: Thank you.
13 CHAIRWOMAN KRUEGER: Thank you.
14 Assembly?
15 CHAIRWOMAN WEINSTEIN: No one.
16 CHAIRWOMAN KRUEGER: Oh. I might just
17 have one or two questions for you, Dennis.
18 Thank you for being here.
19 I know this isn't your bailiwick, but
20 you're so good --
21 INSPECTOR GENERAL ROSEN: I'm sorry,
22 I'm having trouble hearing you.
23 CHAIRWOMAN KRUEGER: I'm sorry. I
24 said this question is not about Medicaid

1 fraud, but I know that you have developed all
2 kinds of systems for tracking patterns of
3 abuse, and that's why your agency --
4 INSPECTOR GENERAL ROSEN: I'm sorry,
5 for tracking what?
6 CHAIRWOMAN KRUEGER: Patterns of
7 abuse.
8 INSPECTOR GENERAL ROSEN: Yes.
9 CHAIRWOMAN KRUEGER: Okay, sorry, get
10 really close. Thank you.
11 So you have all this talent on your
12 staff that can help find out when bad things
13 are happening. So I'm working on a different
14 issue with my staff, and actually the
15 Governor made reference to it in his budget,
16 which is tracking down healthcare providers
17 who are in fact perhaps guilty of sexual
18 harassment or abuse, may have been found
19 guilty in another state, may have not been
20 correctly tracked from a court case through
21 the Office of Professional Licensing, through
22 the office that tracks doctors specifically
23 within Department of Health.
24 And I know I have been talking with

1 the court system about -- they of course know
2 when a doctor is found guilty of something.
3 They don't think they're supposed to
4 necessarily report that somewhere. And then
5 you've got separation between licensing
6 through Adult Professions in SED, but also
7 some tracking within DOH.
8 I guess it's more of a question do you
9 think if I asked the Governor to let you take
10 a look at all this you could help us figure
11 out how, when there are bad players -- and
12 I'm not saying there's a huge number of them,
13 but we keep finding cases where they were
14 given a license even though they had lost
15 their rights in other states, where they were
16 found guilty in our courts of abuse and
17 harassment, but they were just allowed to
18 continue to practice.
19 It just seems to me we don't have a
20 system in place to make sure that we are not
21 allowing bad apples to continue to practice
22 medicine. And I think that you and your
23 staff might be the right ones to take a look
24 at and propose a better system for tracking.

1 INSPECTOR GENERAL ROSEN: We -- I
2 mean, that's the kind of thing I'd be happy
3 to discuss.
4 We do have some systems in place for
5 tracking some of the kinds of behavior you're
6 talking about. We work very closely with law
7 enforcement. And, for example, if there's a
8 conviction involving, say, a medical
9 professional, we typically -- we will know
10 about it, and we will exclude that person
11 from the Medicaid program.
12 The Justice Center sends us referrals.
13 You know, you mentioned cases of abuse, for
14 example, of harassment. Very often the
15 Justice Center gets those kinds of reports,
16 and they have an obligation to refer those
17 kinds of complaints to us.
18 So that, again, I'm always happy to
19 discuss enhancing the system. But those are
20 just a couple of examples of how we are
21 involved in a significant way in those kinds
22 of issues right now.
23 CHAIRWOMAN KRUEGER: Okay, thank you.
24 I'm going to follow-up with you then after

1 the hearings are done. Thank you.
2 INSPECTOR GENERAL ROSEN: That would
3 be fine.
4 CHAIRWOMAN KRUEGER: Okay, I think we
5 are done. So thank you very much for being
6 with us today.
7 INSPECTOR GENERAL ROSEN: Thank you.
8 CHAIRWOMAN KRUEGER: Thank you.
9 Our next -- we have finally now
10 completed the government representatives, for
11 people keeping score. We have our first
12 panel. Again, from now on, for the rest of
13 the duration of the hearing, each separate
14 agency gets five minutes. So if it's a panel
15 of two different agencies, they each get five
16 minutes. And the questions will be three
17 minutes from the legislators unless they are
18 the chair of the relevant committee, they get
19 five minutes. Okay?
20 But again, for legislators, there is
21 no group who are sitting here who want to
22 testify who won't be happy to follow up with
23 you after a hearing if you want to get more
24 information from them. That's why they're

1 here. So even though we are making the
2 timeline short because we have -- for those
3 tracking, we have four more pages of people.
4 We're here because we're interested. The
5 testimony goes up online. And seriously, if
6 you're in this audience and there's any
7 legislator that seems to voice interest but
8 we cut them off, you find them. That's what
9 you want to do, so you find them and follow
10 up with them.
11 So good afternoon to the Healthcare
12 Association of New York, HANYS, Bea Grause,
13 and also to Greater New York Hospital
14 Association, David Rich.
15 MS. GRAUSE: Great. Good afternoon.
16 CHAIRWOMAN KRUEGER: Good afternoon.
17 MS. GRAUSE: Good afternoon. I'll
18 start out.
19 Chairs Krueger, Weinstein and Rivera,
20 and other members of the committee, my name
21 is Bea Grause. I'm president of the
22 Healthcare Association of New York State.
23 And thank you for this opportunity to discuss
24 our '20-'21 Executive Budget proposal.

1 As I have found myself saying many
2 times recently, there are no simple solutions
3 to complex problems. But that said, we
4 believe that the reasons for this staggering
5 $2.5 billion state Medicaid gap are quite
6 clear.
7 First of all, healthcare workers need
8 a liveable wage. Second, demand for
9 healthcare services is increasing, in part
10 due to our aging population and, as has been
11 mentioned before, increased enrollment. We
12 do absolutely stand ready to help close this
13 gap and agree with the Governor's parameters
14 around helping to protect beneficiaries as
15 part of that effort. Our goal, as the
16 state's hospitals across the state, is to
17 preserve access to care for all by keeping
18 our doors open.
19 Hospitals generally across the state
20 are the heart of their community. They are
21 often the largest employer. Collectively,
22 our hospitals produce $170 billion as one of
23 the state's largest economic engines.
24 Our hospitals and nursing homes across

1 the state are financially vulnerable, and
2 cutting provider payments will cut them to
3 the bone. I think for the MRT process, our
4 logic and our priorities are to protect
5 funding, which in turn protects jobs. And
6 healthcare is primarily people taking care of
7 people. Sixty percent of a hospital's --
8 more than -- two-thirds of a hospitals budget
9 is largely related to payroll, and for
10 nursing homes about 80 percent or more are
11 related to payroll. So those jobs really are
12 the people taking care of the people.
13 So we want to protect that funding.
14 We certainly want to focus on the cause of
15 the deficit, as I alluded to before, and we
16 believe looking at the structure of the cap,
17 the global cap, needs to be looked at.
18 Healthcare spending has exceeded general
19 economic growth for decades, so I think not
20 only does the cap need to be raised, but also
21 the mechanics of the cap need to be addressed
22 as well.
23 We certainly support the managed care
24 provisions in the Governor's budget and will

1 help to work those in through the MRT process
2 as needed. And if new revenues arise in the
3 budget process, we think that they should
4 also go to close the Medicaid gap.
5 And in closing, our hospitals and
6 nursing homes again stand in partnership with
7 our physicians, our nurse caregivers. And
8 together we have made significant progress in
9 quality and patient safety and cost
10 containment, and we want to continue together
11 to take New York State forward on healthcare
12 reform and will participate in the MRT to
13 help make that happen.
14 Thank you.
15 CHAIRWOMAN KRUEGER: Thank you.
16 MR. RICH: Thank you. Good afternoon.
17 First I'd like to commend the Governor
18 for once again impaneling a Medicaid Redesign
19 Team. Ever since 2011, he has made clear
20 that collaboration works better than
21 confrontation when it comes to Medicaid
22 policy and that if we are to make hard
23 decisions, they should be made together, with
24 expert input and, most importantly, with the

1 goal of protecting Medicaid beneficiaries and
2 communities. We look forward to working with
3 the Legislature and the MRT.
4 But make no mistake, we confront a
5 huge challenge. The MRT has been charged
6 with finding 2.5 billion in Medicaid savings
7 for the next fiscal year. To give you a
8 sense of the magnitude of this, if there were
9 an across-the-board cut to all Medicaid
10 payments to achieve 2.5 billion in savings,
11 it would require a 10 percent cut in Medicaid
12 payments to every hospital, nursing home and
13 every Medicaid provider in the state.
14 And the actual impact would be a
15 $5 billion cut, as you know, since the
16 federal matching dollars would be cut as
17 well. A $5 billion across-the-board cut to
18 all providers would absolutely force
19 hospitals, nursing homes, clinics and other
20 providers to close. So we are all facing a
21 huge challenge, and we must find
22 alternatives.
23 We will judge the outcome of the
24 budget process according to the following

1 five principles. First, any new revenues
2 must be dedicated to Medicaid. If revenues
3 become available from settlements, tobacco
4 taxes, revenue reestimates, rainy day funds
5 or other sources, they must be dedicated to
6 Medicaid. Hospitals and other safety-net
7 providers, and the patients they serve,
8 should not be cut if other revenues can
9 lessen the impact.
10 Second, the Medicaid global cap must
11 be reformed. The cap, as you know, came out
12 of the first MRT in 2011, but at that time we
13 had approximately 4 million Medicaid
14 enrollees. We now have more than 6 million,
15 and yet the annual global cap increase has
16 actually gone down from 4 percent in 2011 to
17 2.9 percent today.
18 And there have been unintended
19 consequences. Because there was no
20 adjustment for enrollment in the cap,
21 hospitals and other providers went a decade
22 without a Medicaid rate increase, so Medicaid
23 rates now cover only 72 percent of costs,
24 contributing to the financial distress of

1 many of our safety-net hospitals.
2 The global cap should be reformed so
3 the legitimate growth due to enrollment,
4 aging and other factors are taken into
5 account.
6 Three, the true drivers of growth must
7 be reformed. Many people have talked today
8 about the fact that the Managed Long Term
9 Care Program is one of the main drivers of
10 growth, and any serious solution to the
11 problem must address that program.
12 Fourth, if there are hospital cuts,
13 safety-net providers must be protected.
14 Hospitals with high volumes of Medicaid
15 patients are disproportionately harmed by
16 Medicaid cuts. There are already 30
17 hospitals on the watch list for closure who
18 rely upon regular state support just to keep
19 the lights on. Other hospitals are also on
20 the brink. It makes no sense to cut Medicaid
21 rates for the hospitals with one hand just to
22 bail them out with the other. They and their
23 communities need to be protected.
24 And finally, if there are hospital

1 cuts, the state should find ways to help
2 hospitals weather them. In this vein, we
3 strongly support the provisions in the budget
4 that would put an end to some insurance
5 companies' bad behavior. Insurers deny
6 payment for medically necessary services that
7 consumers have paid premiums for. And so we
8 urge you to support the insurance reforms
9 that are in the Governor's budget. I've
10 added to my testimony a summary of those
11 reforms.
12 Thank you.
13 CHAIRWOMAN KRUEGER: Thank you.
14 Senator Gustavo Rivera.
15 SENATOR RIVERA: Good afternoon,
16 folks. Thank you for your patience.
17 There's a couple of things that I'm
18 glad that you folks went on the record --
19 certainly David, and I'm not sure if Bea, on
20 behalf of HANYS, also agrees with some of
21 this -- but as far as the global cap must be
22 reformed, I guess that there's agreement
23 about -- and I agree with you a hundred
24 percent. As far as any new revenues must be

1 dedicated to Medicaid, I agree with that as
2 well.
3 However, I just wanted to ask a
4 general question about you did speak about
5 revenues become available from settlements,
6 reestimates, higher than expected rainy day
7 funds, or other sources. Is either HANYS or
8 Greater New York taking a position on the
9 possibility of raising revenues by taxing
10 wealthier individuals?
11 MR. RICH: We have not, no.
12 SENATOR RIVERA: Okay.
13 MS. GRAUSE: We have not either.
14 SENATOR RIVERA: Just had to check.
15 However, the "other sources" is in there, so
16 I would agree with you if we have the biggest
17 hole, that we should certainly plug it with
18 that money.
19 If there are hospital cuts, safety
20 nets must be protected, I absolutely agree
21 with you there, and I'm guessing that there's
22 agreement between the both of you.
23 All right. So let's talk a little bit
24 about MRT. It is immediately after the

1 governmental representatives speak, then you
2 folks come up, which certainly speaks to the
3 importance of the organizations that you
4 represent and the entities that you represent
5 across the state. Have you been approached
6 officially by anybody in the Governor's
7 office related to membership of either your
8 organizations in the MRT?
9 MR. RICH: We have not, no. We
10 haven't been asked to be on the MRT.
11 SENATOR RIVERA: Would you agree with
12 me that -- I keep saying the date because I
13 can't really believe it, that it is
14 January 29th and that we have, according
15 to -- certainly you have experts in both of
16 your organizations that have read the same
17 documents that we've read and have done the
18 analysis yourselves. So is there
19 something -- and I'm sure that you've been
20 here all day, without -- I obviously have a
21 very strong opinion about certain things, but
22 without the extra sass, if you will, was all
23 the conversation that we had related to what
24 was in or not in the documents accurate?

1 Related to is the -- is there anywhere
2 that your folks found any sort of reference
3 to what the MRT would actually do, the
4 timeline of it, the membership -- was there
5 anything in the documents that you saw that I
6 didn't?
7 (Overtalk.)
8 MR. RICH: I don't think so. I think
9 you read the provision earlier.
10 SENATOR RIVERA: Yeah, I just want to
11 make sure. Would you agree, particularly
12 considering the seriousness of the crisis
13 that you both acknowledge in your testimony
14 here, that we probably would need more time
15 to really consider this, and we would need
16 more participation certainly from both of
17 your organizations and certainly from the
18 Legislature, to actually try to solve this
19 problem? Would you agree that that would be
20 the best way to achieve this?
21 MS. GRAUSE: I think -- you know, I
22 think you are bound by the deadline of the
23 budget for March 31st, and I do think that
24 progress will be made. There are -- there

1 will be many ideas, I'm sure, put on the
2 table that will go into the budget that will
3 not be entirely complete or as completely
4 thought out, I guess, as they need to be, and
5 that will continue after April 1st. Because
6 I think -- again, I think the challenges
7 around the cause of the Medicaid gap are
8 related to demand and how to provide -- and
9 largely how to provide services more
10 efficiently, and that will take time to
11 figure out. So we'll move into another phase
12 I think.
13 SENATOR RIVERA: Would you agree that
14 it would be easier to figure all that out if
15 there was full information provided by the
16 administration about the causes of the crisis
17 and the cost drivers and how they calculated
18 some of these proposals -- would any of that
19 be helpful to you or to us?
20 MS. GRAUSE: I think -- I think -- I
21 think -- candidly, I think we talk -- we work
22 on that 12 months a year. So I think we
23 generally understand that. And I do think --
24 SENATOR RIVERA: I only have --

1 MS. GRAUSE: -- one of the good things
2 that -- I think there's goodwill about trying
3 to get that information. I just don't think
4 it's all available in one place.
5 SENATOR RIVERA: All right, gotcha.
6 So I -- and I will acknowledge this -- I only
7 have 40 seconds -- I will say I am thankful
8 that you are looking forward to participating
9 in this process, that you're willing to do
10 it. I'm not sure -- you're seeing goodwill,
11 I'm not necessarily seeing it. I would
12 prefer information to goodwill. And call it
13 bad will if you will, but just tell me
14 where -- what we actually have to deal with.
15 But I'm certainly looking forward to
16 eventually, when we actually have the MRT
17 reshaped -- and maybe you'll be on it, maybe
18 I'll be on it, maybe there will be
19 representatives from the Legislature. I hope
20 that we have an opportunity to kind of work
21 on this, since I know the seriousness of the
22 crisis. And I'm looking forward to working
23 with you regardless, because there's always
24 been goodwill from y'all to us. Maybe not

1 some other people. Thank you.
2 MS. GRAUSE: Surely.
3 CHAIRWOMAN KRUEGER: Thank you.
4 CHAIRWOMAN WEINSTEIN: Assemblyman
5 Cahill.
6 ASSEMBLYMAN CAHILL: Thank you,
7 Madam Chair.
8 Hello and welcome. It's good to see
9 you.
10 MS. GRAUSE: Thank you.
11 MR. RICH: Thank you.
12 ASSEMBLYMAN CAHILL: I don't have any
13 specific questions that will require anything
14 other than your reaction. And I'll start
15 with this.
16 What if every single part of the
17 Governor's budget proposal and all the likely
18 things that will come from the MRT were to
19 become a reality? What would happen to the
20 hospitals in New York State as a result?
21 MS. GRAUSE: Do you mean if there was
22 a $5 billion reduction, is that what you're
23 asking? Just want to --
24 ASSEMBLYMAN CAHILL: Well, if that's

1 what the Governor's budget proposal would --
2 MS. GRAUSE: Then that would be the
3 impact, that would be the impact on
4 providers.
5 Again, I think as David alluded to
6 before, I think we have all different types
7 of hospitals across the State of New York.
8 Whether you're a small rural hospital or a
9 large academic hospital or a -- the world's
10 largest public hospital, they are all
11 structured very differently, they all see --
12 they -- you know, healthcare -- politics is
13 local, healthcare is local. And they are a
14 reflection of their communities. And
15 particularly in low-income communities, both
16 low-income rural and urban, those hospitals
17 would be devastated. It would be very
18 difficult to keep their doors open.
19 ASSEMBLYMAN CAHILL: I believe your
20 written testimony indicates that about half
21 of the hospitals in New York State are
22 operating with a negative balance right now.
23 MS. GRAUSE: Yes, that's correct.
24 ASSEMBLYMAN CAHILL: If they're

1 already operating at a negative balance and
2 they see reduced Medicaid, if they see
3 reduced other hospital subsidies, if they see
4 increased costs for medical malpractice, if
5 they find a tax on their capital
6 improvements, how do they survive?
7 MS. GRAUSE: Well, hospitals --
8 hospitals are constantly working to make a
9 margin. And so to reduce their expenses, you
10 know, and try to make sure that they have
11 enough resources to restore their equipment
12 and buildings and tools that physicians and
13 nurses need -- so the expense pressure is
14 tremendous, but they're trying to reduce that
15 expense pressure as much as they can and find
16 new ways and more efficient ways to provide
17 services so that they can generate a margin
18 at the end of the day.
19 All of our hospitals are
20 not-for-profit. And again, I think,
21 depending on their comparative financial
22 health, they are all trying to become more
23 efficient over time. It's just difficult in
24 a very short period of time, if you're going

1 to have a significant rate reduction, how you
2 recover from that in such a short period of
3 time.
4 And that's why I think we support the
5 Governor's proposals around managed care.
6 And we've -- last year and again this year
7 are looking for things like regulatory
8 relief, CON relief, workforce flexibility
9 that would help reduce that expense burden
10 for hospitals. Again, make it easier for
11 them to maintain a margin.
12 MR. RICH: But I think that's why your
13 question is very well taken, and that's why
14 we believe that the number needs to come down
15 from where it is, because there's no way that
16 the provider community can take a $5 million
17 cut, let alone the patients and the residents
18 that they serve. And also why we need to
19 protect safety-net institutions, many of whom
20 would be in the 50 percent that you
21 mentioned.
22 But also we hope we can find
23 alternatives to the usual types of just sort
24 of slash-and-burn cuts that governors have

1 put out in the past, and that's why again I
2 think it's -- we're supportive of the idea of
3 having the group come together so we can find
4 some alternatives.
5 MS. GRAUSE: And again, if I could
6 just add to that, you know, if it was easy to
7 do, we would have done it already. We're all
8 taxpayers, we're all consumers, and we all
9 want to make healthcare more affordable for
10 everyone. It's good for the economy.
11 And so I think the MRT process will
12 help us to have that dialogue. Again, I
13 think -- I know it will be challenging. And
14 I know there's no easy answers. But I think
15 there's a lot of goodwill to try to at least
16 have that dialogue.
17 ASSEMBLYMAN CAHILL: I would just
18 piggyback on Senator Rivera's comment that,
19 you know, there are many, many things in your
20 memos and in your testimony, written and
21 oral, where you've indicated support and
22 concern about different positions. But on
23 the question of general revenue, I think
24 there's been a little bit of silence. And it

1 would be very important for us to hear from
2 those folks who are responsible, oftentimes
3 the largest employer in our community,
4 certainly entities that we rely upon for our
5 times of need, to register in and say this is
6 the real choice that our taxpayers are facing
7 in New York State. And it would be great to
8 hear from you on that front.
9 Good luck. We're going to do the best
10 we can for you through this budget process.
11 MS. GRAUSE: Thank you very much.
12 MR. RICH: Thank you. Appreciate it.
13 CHAIRWOMAN WEINSTEIN: Senate?
14 CHAIRWOMAN KRUEGER: Senator Robert
15 Jackson.
16 SENATOR JACKSON: Good afternoon. Can
17 you hear me?
18 MR. RICH: Yes.
19 MS. GRAUSE: Yes.
20 SENATOR JACKSON: Thank you for
21 staying the course.
22 I don't know if you were here earlier
23 when I raised some questions to the
24 commissioner and especially about the new

1 team that's going to be developing. I don't
2 know what it is, all I know is that the
3 Governor said that there's going to be two
4 individuals, there may be more. I hope that
5 some of the advocates are on there and people
6 with knowledge about the system itself.
7 But with respect to the Greater
8 New York Hospital Association, I have a huge
9 hospital in my district, Columbia
10 Presbyterian New York Medical Center, which
11 is a big conglomerate of -- and I'm concerned
12 about the impact it's going to have on them,
13 I'm concerned about -- earlier I talked about
14 Isabella Geriatric Center and small hospitals
15 and small nursing homes.
16 So I can't visualize, and maybe you
17 can help me do this, how are we going to make
18 those huge cuts and the services are not
19 going to be cut? Just -- that doesn't match
20 with me knowing that if you're going to have
21 to deal with that, obviously we're going to
22 have to reduce services or somehow we're
23 miracle workers. And so I just want to know
24 from your perspective, from the advocacy,

1 from the hospitals and New York's health
2 associations, sort of paint a picture for me:
3 How can we do that?
4 MR. RICH: If there are huge cuts,
5 there will definitely be service cuts.
6 There's no question.
7 So, you know, one of the tasks given
8 to the MRT was to have no impact on
9 beneficiaries. But as I mentioned before, if
10 you got to the end and then we're at a
11 10 percent across-the-board cut to every
12 hospital and nursing home in the state, there
13 would absolutely be an impact on
14 beneficiaries.
15 So we need to try to find solutions
16 that are different, that are structural
17 reforms that can work over time. But I also
18 think, you know, as I said before, we need to
19 bring that number down so that there are not
20 huge cuts that will really have terrible
21 impacts.
22 SENATOR JACKSON: So this is to be
23 continued.
24 And the chair of the Health Committee,

1 Gustavo Rivera, had indicated: Do you think
2 that really between now and the budget
3 there's enough time to do that, considering
4 the complexity of it, and understanding the
5 goal is, as the Governor said, is to cut the
6 budget but continue the services that we're
7 providing? And quite frankly, I don't see
8 how we can do that.
9 And so I'm willing to listen and to
10 observe, but I'm just curious.
11 MS. GRAUSE: I do think ideas will be
12 generated by April 1st, but I do think the
13 implementation of those ideas will take time,
14 I think as David alluded to. So it will go
15 beyond April 1st, but the ideas -- we can
16 generate ideas before then.
17 SENATOR JACKSON: To be continued.
18 Thank you.
19 CHAIRWOMAN KRUEGER: Thank you.
20 CHAIRWOMAN WEINSTEIN: Assembly Ra.
21 ASSEMBLYMAN RA: Thank you.
22 Just wondering if you can just give
23 some thoughts on the surcharge for
24 Certificate of Need that's proposed in this

1 Executive Budget proposal.
2 MS. GRAUSE: It's an expense. I mean,
3 I think as was -- the commissioner testified
4 earlier that 3 percent will be assessed on
5 the capital costs of a hospital's
6 application, or the cost of the application,
7 unless those funds were granted from the
8 state originally.
9 MR. RICH: Yeah, we're trying to work
10 with our members to understand what projects
11 do they have coming up and therefore what
12 would this new fee mean in terms of adding
13 significant cost onto those projects. And so
14 we will have a more full understanding of it
15 that we'll be able to get back to you with.
16 ASSEMBLYMAN RA: Okay. Because I
17 think definitely, you know, in part of the
18 state, but particularly downstate with the
19 cost of construction and everything involved
20 in that, you know, adding on an additional
21 cost when we have I think needs that our
22 hospitals are seeking to meet by engaging in
23 new construction, anything that's going to
24 create a disincentive to that I don't think

1 is going to ultimately serve the public or
2 the patient.
3 So if you have further information as
4 your members are going through it, I'd
5 appreciate if you can share them with us.
6 MR. RICH: Absolutely.
7 MS. GRAUSE: Certainly.
8 ASSEMBLYMAN RA: Thank you.
9 CHAIRWOMAN WEINSTEIN: Thank you.
10 CHAIRWOMAN KRUEGER: Thank you.
11 Senator Ritchie.
12 SENATOR RITCHIE: I represent a very
13 rural area in the North Country. We have
14 very rural hospitals and nursing homes. Many
15 of the hospitals and nursing homes that when
16 I started nine years ago were solvent and in
17 the best shape are now teetering on potential
18 closure. You're talking about possibly
19 cutting services? Many of the hospitals that
20 I represent, they don't have a lot of the
21 services that other hospitals have, they have
22 the basic services. I don't really know what
23 else they could possibly cut out.
24 So I guess my question is

1 hypothetical. If a cut like that goes into
2 place, how many potential hospitals or
3 nursing homes are going to have to close
4 their doors?
5 MS. GRAUSE: I just want to be clear,
6 we don't support -- we support reducing that
7 $5 billion in order to avoid cutting
8 services. So we are absolutely going to work
9 as hard as we possibly can to make sure that
10 hospitals and nursing homes and other
11 providers can keep their doors open, can
12 maintain their services, and make sure that
13 they are taking care of the needs of their
14 communities across the State of New York.
15 So that's what we're coming to the
16 table with and trying to make sure that we
17 can try to achieve that through some
18 problem-solving and creative thinking, and
19 potentially new revenues, and as I said to
20 Chairman Cahill, through ideas that would
21 help to reduce the expense of providing those
22 services so that our non-for-profit providers
23 could maintain a margin. So that's what
24 we're really hoping to avoid.

1 And again, I think we know we have
2 a -- I know it's a challenge, and that's a
3 big number, but again, I think we are going
4 with the hope and intention that we can be
5 creative in terms of reducing the expense of
6 delivering care, and perhaps finding more
7 efficient ways to provide those healthcare
8 services so providers can keep their doors
9 open and can meet the needs of their
10 community.
11 SENATOR RITCHIE: So my fear just is
12 with any kind of cut we're going to see some
13 significant potential closures. Because the
14 ones that were viable a few years ago can't
15 pay payroll now. And if they have any cuts,
16 I don't know what's going to happen to them.
17 And in the area that I represent there
18 are many miles to the next hospital.
19 Sometimes when there's five foot of snow on
20 the ground, we need some kind of medical
21 services in the area.
22 MS. GRAUSE: Absolutely. And I think
23 as David said earlier, many of those
24 hospitals are supported by state dollars

1 today, and it makes no sense to cut their
2 rates on one side and then having to provide
3 state funding from a different bucket on
4 another. So we completely agree with you.
5 SENATOR RITCHIE: Thank you.
6 CHAIRWOMAN KRUEGER: Thank you.
7 I just have two questions -- oh, you
8 have another Assemblymember?
9 CHAIRWOMAN WEINSTEIN: Yes, a late
10 starter. Assemblyman Byrne.
11 ASSEMBLYMAN BYRNE: Yes, thank you,
12 Chairwoman.
13 So two questions really, and then I'll
14 just let you answer. One, I've heard you
15 mention revenue raisers and if there's some
16 specific proposals that you would like MRT II
17 or the Legislature to think over, if you
18 could get a little more specific on that.
19 Obviously it's always a little bit of
20 a touchy subject. Nobody likes to increase
21 taxes or fees on anybody. Same reason why a
22 lot of folks wouldn't want to have to pay an
23 additional surcharge on different capital
24 improvements, because it eventually can get

1 passed down to consumers.
2 But -- so that's one question. Number
3 two, we do know who the chairs of the MRT II
4 are, right, Mr. Dowling and Rivera. And
5 since you're the first people up here on the
6 dais that don't necessarily work for the
7 government, who would you -- not necessarily
8 a person, but one of the questions we've had
9 is -- or concerns, is more transparency and
10 balance on the MRT II.
11 So what types of industry would you
12 like to see on there? Obviously the
13 hospitals, and I think they have a voice
14 there too. I personally would like to see a
15 balance of -- a large variety of
16 stakeholders, so everybody who is going to be
17 affected by this has a voice. But what other
18 types of people in healthcare or groups in
19 healthcare do you believe should be on the
20 redesign team?
21 MR. RICH: Yeah, I mean I think we
22 would totally agree that it should be a broad
23 group, a broad representation, including
24 consumers, absolutely, as well as nursing

1 homes --
2 MS. GRAUSE: Labor.
3 MR. RICH: -- home health, labor,
4 et cetera. And I think -- you know, I think
5 it wasn't perfect in 2011, I think they tried
6 to cover a lot of different stakeholder
7 groups. But everyone's going to need to be
8 at the table, because we need a lot of good
9 ideas from people coming from a lot of
10 different walks of life.
11 In terms of revenues, you know, I put
12 a few examples, including rainy day funds, in
13 there. I think from my perspective, it's
14 raining, when you look at the Medicaid budget
15 as it currently stands and as it was
16 proposed. And also, you know, every now and
17 then another settlement gets announced with a
18 different industry by the Attorney General,
19 and so we'd like to see some of those
20 settlement funds dedicated to Medicaid as
21 well.
22 MS. GRAUSE: Recreational marijuana is
23 another one where if it's passed, then we
24 think the revenues should go to healthcare.

1 ASSEMBLYMAN BYRNE: Okay, so that's a
2 good point. Because when you mention the
3 settlements, one concern I just have is
4 putting revenues that could be considered
5 one-shots and then putting it into something
6 like a Medicaid program. So you want to make
7 sure that if we're going to be funding it, it
8 should be sustainable --
9 MS. GRAUSE: Recurring, yeah.
10 ASSEMBLYMAN BYRNE: -- with our
11 existing revenues. And it's a great big
12 budget, so there's a lot of different things
13 we can look at. But that was just one of the
14 concerns I had.
15 So thank you for your comments and for
16 your time.
17 CHAIRWOMAN KRUEGER: Thank you. Now I
18 have just two short questions.
19 One, did you hear me ask earlier if
20 anyone saw something in the budget about
21 sweeping DSRIP? Even though we're three
22 years behind from the feds, but I'm assuming
23 you and other providers have spent the money.
24 Were you under the impression there was a

1 possible sweep of those funds if they ever
2 show up?
3 MR. RICH: So I had seen -- actually
4 in today's Crain's Health Pulse, they were
5 reporting on the Assembly report on the
6 budget where they seemed to indicate that for
7 this year budget actions there were some
8 pools that were being swept, and one of
9 the DSRIP pools was one of them. But I have
10 not actually heard directly from the
11 Executive about how you actually get to the
12 $599 million in current-year actions that
13 they mention in the budget documents.
14 CHAIRWOMAN KRUEGER: And I'm going to
15 take the leap that sweeping money people have
16 already spent would not be very popular in
17 the healthcare universe.
18 MS. GRAUSE: That's a good leap.
19 MR. RICH: Correct.
20 MS. GRAUSE: That would be a good
21 leap.
22 CHAIRWOMAN KRUEGER: Thank you.
23 And assuming -- we all know why the
24 Medicaid costs are going up. I don't even

1 know why the Governor is surprised. I mean,
2 everybody knew exactly what was happening and
3 why. Just -- it was demographic reality,
4 based on what happened.
5 So it's very hard to ask you this,
6 because you're the representatives of
7 hospitals. But is it conceivable that in
8 some parts of the state we actually might
9 have an oversupply of hospitals and we could
10 best address our problem of having to limit
11 how much we spend in healthcare by saying to
12 a few, sorry, there's enough here? Or saying
13 no to hospitals who still are wanting to
14 expand.
15 Can you ever imagine your associations
16 getting to a place where you assisted
17 government with those kinds of hard
18 decisions?
19 MS. GRAUSE: So it was before my time
20 here in New York State, but you have already
21 had the Berger Commission.
22 But I think what is happening already,
23 in a very dynamic market, is that the
24 location of services and whether or not a

1 hospital stays a hospital or they close part
2 of it and provide other parts of services, is
3 already happening across the state. So that
4 is actually a very dynamic part of the New
5 York State market today.
6 So there's -- you know, most of the
7 care is migrating to outpatient and now
8 community-based services, so the delivery of
9 care, so to speak, is becoming decentralized
10 very quickly. So that is in fact already
11 happening.
12 MR. RICH: And we have seen -- we're
13 seeing it in Brooklyn right now in terms of
14 the One Brooklyn project and the overall
15 Brooklyn project where, based on actual data,
16 they decided that, you know, Kingsbrook
17 should downsize and provide only certain
18 services, Interfaith should provide certain
19 services, and Brookdale would remain a trauma
20 center and then also try to figure out how to
21 have capital dollars to create more
22 ambulatory care services, et cetera. That's
23 the kind of planned, using-data approach that
24 we would certainly support.

1 And so yes, if there were
2 opportunities with the state to really use
3 data and figure out, particularly for very
4 struggling institutions, what does the
5 community need first and is what they're
6 getting right now exactly what they need, or
7 should it look a little bit differently, just
8 as they've been doing in Brooklyn.
9 MS. GRAUSE: And I think to add to
10 that, I would add the onset of new
11 technologies, and that is another -- you
12 know, again, I'm not sure we can get it all
13 finished by April 1st, but I think there are
14 a lot of new technologies that could benefit
15 consumers and help them with their
16 decision-making, really help them to
17 understand the services that are in their
18 communities, that could do -- could produce a
19 result such as getting them to the right
20 service at the right time and the right
21 place. And that would be a positive.
22 CHAIRWOMAN KRUEGER: Thank you both.
23 I think we're done with this panel. Yes,
24 thank you very much.

1 MS. GRAUSE: Thank you.
2 CHAIRWOMAN KRUEGER: All right, next
3 up, 1199, Helen Schaub.
4 Good afternoon.
5 MS. SCHAUB: Good afternoon. Thank
6 you for having me.
7 CHAIRWOMAN KRUEGER: Thank you.
8 MS. SCHAUB: So, you know, in the
9 interests of everyone's time here, certainly
10 yours and all the other folks who are waiting
11 to testify, I don't think I'll repeat some of
12 the points that previous speakers have made
13 that are in the written testimony that you
14 have. Obviously everyone knows Medicaid is a
15 hugely important program for patients, for
16 consumers, for people with disabilities, for
17 children, many -- 6 million people throughout
18 the state.
19 We share the concern about the impact
20 that really $5 billion of cuts would have on
21 that whole system and on the people who
22 depend on it. And certainly we share the
23 idea that's been raised by many of you and
24 others that there has to be a serious look at

1 the adequacy of the Medicaid cap.
2 I would certainly add to that, you
3 know, in the framework of the cap, there is
4 only one solution to overspending the cap,
5 which is to cut until you get under it. And
6 so raising the cap to acknowledge necessary
7 expenses is the way to avoid those cuts. And
8 thinking about how it should grow going
9 forward is certainly the way to not be in
10 that situation again and again.
11 We do think that there is value in
12 revisiting some of the decisions, the policy
13 decisions that were made by the MRT nine
14 years ago. And I want to focus a little bit
15 on the question of managed long term care,
16 since it's come up over and over again,
17 rightly, as one of the drivers of growth
18 within this program.
19 And the point that we'd like to make
20 is that there are some structural incentives
21 built into that program that we think have
22 driven extraordinary growth. I mean, the
23 population is aging, absolutely, and it's one
24 of the reasons we have to do everything we

1 can to make the Medicaid program as efficient
2 and as effective as possible, because there
3 will be increasing need and increasing
4 pressure for services under the Medicaid
5 program.
6 But under the -- the population, for
7 example, if you think about people over 85
8 who are likely to need long-term-care
9 services, that population in New York State
10 is growing about 3 to 4 percent a year. But
11 the Managed Long Term Care Program has been
12 growing 13 percent a year, even after all of
13 the mandatory populations were absorbed. So
14 we think there is a disconnect there, and it
15 has to do with the financial incentives that
16 were built into the plans.
17 Originally when the MRT came up with
18 this care-management-for-all idea, their
19 vision, explicitly laid out, was to move
20 people into fully capitated or fully
21 integrated managed-care plans that would
22 manage both the Medicaid and the Medicare
23 spend. And, you know, for people who are --
24 who need a lot of services, there is some

1 logic to that. If you invest more in the
2 long-term-care services, you have
3 high-quality home care, you keep people out
4 of the hospital, you actually are able to
5 capture that savings from Medicare.
6 But what happened is the state set
7 up -- you know, tried to do that, set up this
8 fully integrated duals Advantage program.
9 They didn't do that very well, there were a
10 bunch of missteps in how it got set up. It's
11 now shut down, as of the end of last year.
12 So the vast majority of folks who are
13 dually eligible, Medicare, Medicaid, need
14 long-term-care services, are in what's called
15 a partially capitated program. It only
16 manages the Medicaid spend. The vast
17 majority of the spend there is home care
18 services. Because nursing home has been kind
19 of in and out, but mostly at this point out.
20 So if you're a managed long term care
21 plan and you have a capitated payment and
22 you're paying for home care services, there's
23 only a few ways you can kind of manage within
24 that. On the home care side, you can either

1 try to provide less services or pay less for
2 those services, and both of those, frankly,
3 have proven a little bit difficult for the
4 plans.
5 The minimum wage was going up; hard to
6 drive down provider rates when the minimum
7 wage was going up, although certainly they
8 tried. Hard to sell your plan as the plan
9 that you can enroll in and get your services
10 cut, so from a competitive point of view they
11 didn't like to do that.
12 And so a number of plans chose a third
13 alternative, which was to find new people.
14 Even though they were banned from marketing,
15 they were able to use the for-profit fiscal
16 intermediaries, who had kind of emerged when
17 the MRT essentially deregulated the Consumer
18 Directed Program -- an explosion of these new
19 for-profit companies. They had no such
20 marketing ban. They could go out and hand
21 you a flyer that says, you know, Are you
22 taking care of your mom? You can get paid to
23 do that. Which certainly anybody who lives
24 in New York City has gotten one of those

1 flyers, heard an ad, seen it in the
2 communities.
3 They were able to use those fiscal
4 intermediaries to circumvent the ban on
5 marketing and to grow their plans. We think
6 that profit incentive for the plans has been
7 one of the reasons for this extraordinary
8 growth, and we think the MRT should take a
9 hard look at that in terms of restructuring
10 the system going forward.
11 CHAIRWOMAN KRUEGER: Thank you for
12 moving through that so quickly.
13 Questions? Senator Gustavo Rivera.
14 SENATOR RIVERA: Thank you.
15 Thank you for that perspective, and I
16 certainly agree with you that we need to look
17 very closely at the cap as well as just
18 redesign programs so that -- to create
19 incentives so that people are taken care of,
20 not that certain folks take advantage of it
21 for monetary purposes.
22 But I did want to also ask, like I did
23 the earlier folks who -- both Greater New
24 York and HANYS. So for the record, has 1199

1 been reached out to be part of the MRT
2 process?
3 MS. SCHAUB: No. No.
4 SENATOR RIVERA: Okay. It is -- do
5 you share the concern that we might not
6 have -- that the time frame is really, really
7 tight to be able to come up with something?
8 MS. SCHAUB: So I would say a couple
9 of things on that. I think, you know, as
10 many people did when we heard about the MRT,
11 I, you know, went back to my files of what
12 happened in 2011. The time frame was not
13 much longer, I will say. It was slightly
14 longer, but it was also a couple of months.
15 SENATOR RIVERA: I would -- and the
16 only reason I would interrupt you is -- you
17 were here during the day, I'm sure -- I asked
18 specifically -- the original MRT had a
19 March 1st deadline to put something forward
20 that then the Legislature could consider to
21 put in the final budget proposal, and also
22 could be part of the conversations that
23 happened in the last couple of weeks related
24 to putting the final budget proposal

1 together.

2 I asked the Department of Health as

3 well as the acting Medicaid Director directly

4 whether I could get a commitment from them

5 that they would -- that this would follow

6 such a timeline. I got no such commitment.

7 And as I've made clear many, many times

8 today, I don't trust that -- you know, trust,

9 you've got to earn it, and I don't have it.

10 So if we are indeed put in a situation

11 in which we are -- it's March 31st and then

12 we have a proposal in front of us, you know,

13 it's just -- I just want to know,

14 particularly considering that you folks were

15 certainly involved in the original

16 back-and-forth putting the original MRT

17 together, you were a very important part of

18 that, like Greater New York and HANYS and a

19 lot of other folks. Just -- is that -- I

20 would argue that concern is warranted. Do

21 you share it with me, or --

22 MS. SCHAUB: So I would say a couple

23 of things. One is, yes, it's a tight

24 timeline no matter how you cut it. If the

1 alternative is draconian across-the-board
2 cuts, you know, we're going to do as much as
3 we can in that timeline to come up with an
4 alternative. I certainly agree everybody has
5 to have a chance to look at what's being
6 considered in those proposals so that it can
7 truly be a stakeholder process, and we would
8 support that.
9 SENATOR RIVERA: Thank you so much.
10 Thank you, Madam Chair.
11 CHAIRWOMAN KRUEGER: Thank you.
12 Assembly.
13 CHAIRWOMAN WEINSTEIN: I just have a
14 quick question, looking through some of your
15 comments. When you talk about that -- the
16 enrollees needing a lower level of care, are
17 you inferring that maybe they don't belong --
18 that the level of care is so low that they
19 shouldn't be part of the program and that
20 there was some fraud involved in their being
21 signed up?
22 MS. SCHAUB: Not necessarily. I
23 mean, I think in a program this big you
24 certainly can argue that there's going to be

1 fraud somewhere. But mostly what we're
2 arguing is that the plans have a financial
3 incentive to find people who are -- who have
4 lower needs of care and enroll them, because
5 they're going to get a full capitated payment
6 for that person and then they have to pay out
7 much less. That's how they can help balance
8 their books. I think if people saw a number
9 of years ago there was this kind of scandal
10 about the social adult day centers, which was
11 a similar idea, that all of a sudden the
12 plans were contracting with the social adult
13 day centers for new enrollees, they would get
14 the full capitated payment, and those in some
15 cases were people who had very low levels.
16 So we think you've got to look at the
17 incentives there -- you know, does it make
18 sense to give a full capitated payment to a
19 plan to manage somebody who needs a small
20 amount of home care, or would it make sense
21 just to pay for that home care directly in
22 fee-for-service rather than pay the plan?
23 We're spending about $800 million in
24 just plan administration in the managed long

1 term care plan -- not including care
2 management, but just the plan administration.
3 Does that really buy us enough to justify
4 that level of expense given where we are?
5 CHAIRWOMAN WEINSTEIN: I just know
6 from my own community, having a lot of people
7 who are either recent emigres, either older
8 Russian-speaking individuals or
9 Chinese-speaking individuals, that this
10 program has helped them.
11 So the question is, moving forward,
12 still allowing them to have their
13 language-specific -- have a caregiver that
14 can speak their language while not blowing up
15 the costs of Medicaid.
16 MS. SCHAUB: And we're certainly not
17 arguing against the CDPAP program. We did
18 support and the Legislature passed last year
19 a reform to raise standards for the fiscal
20 intermediaries. We think 700 mostly
21 for-profit fiscal intermediaries is crazy and
22 that it makes sense to return the
23 administration of that program to the
24 disability community, to the other

1 long-standing providers who can deliver those
2 services in a cost-effective way. It's not
3 about not delivering the services, but who
4 gets paid to deliver the services, both at
5 the plan level and at the intermediary level.
6 CHAIRWOMAN WEINSTEIN: Great. Thank
7 you.
8 CHAIRWOMAN KRUEGER: Thank you.
9 Senator Robert Jackson.
10 SENATOR JACKSON: Well, thank you.
11 Good afternoon. Hi. Thank you for coming
12 in.
13 Have you listened to all the testimony
14 this afternoon and this morning?
15 MS. SCHAUB: Almost all of it.
16 (Laughter.)
17 SENATOR JACKSON: That's good. That's
18 good. So I'm reading here where in your
19 statement you talk about that so many
20 hospitals have less than 15 days' cash on
21 hand and are dependent on extraordinary state
22 support to stay open. Like my colleague was
23 saying, hospitals in her area are on the
24 verge of closing.

1 So 1199, you may have heard me speak
2 about 1199 at Isabella Geriatric Center, a
3 thousand employees up there. And not only
4 there, but Columbia Presbyterian and the
5 New York State Nurses Association.
6 So am I wrong in saying that it
7 doesn't seem to equal out as far as the cuts
8 and maintaining the services? Am I right or
9 wrong?
10 MS. SCHAUB: We are very, very
11 concerned about what huge cuts of that
12 magnitude would mean for the services and for
13 the people who provide the services.
14 SENATOR JACKSON: So obviously, for
15 me -- and 1199 doesn't want any layoffs,
16 New York State Nurses Association doesn't
17 want any layoffs, and other unions that
18 represent -- and a hospital on the verge,
19 they don't want to close. Because as my
20 colleague said, there's big mileage between
21 one hospital and another hospital.
22 So we have to think about how are we
23 going to raise revenue. Is that correct? I
24 haven't really heard people say that, but I'm

1 asking you, is that what we have to start
2 thinking about?
3 MS. SCHAUB: You know, I know the
4 question was posed to the last group. You
5 know, we always say we don't represent any
6 wealthy people. And we do believe that
7 wealthy New Yorkers could pay more to help
8 make sure that we don't have to impose
9 draconian cuts on people who need care in our
10 state, from residents of nursing homes to
11 people who need their local emergency room to
12 stay open.
13 SENATOR JACKSON: Well, I am hoping
14 that this new Medicaid -- what, MRT II, is
15 that what they're calling it? -- has some
16 good people on there that includes some
17 unions, some hospital people, besides the
18 individuals that -- you know, Dennis Rivera
19 represented 1199, and the hospital person has
20 the biggest hospital conglomerate in New York
21 State. So I would hope that they would know
22 that they don't want reductions. Reductions
23 mean employees that we represent will be laid
24 off, and that's not going to help them and

1 their families.

2 So I just want to hear somebody say
3 that we have to look at other options rather
4 than laying off people that may be raising
5 revenue. Because if in fact the design team
6 is going to be able to make cuts but maintain
7 services -- I'm looking to see that happen.

8 MS. SCHAUB: We absolutely support
9 that.

10 The only other thing I would say --
11 you know, and it was a little bit to Senator
12 Krueger's point, very quickly -- is that we
13 are not opposed to any change in the hospital
14 system. Change is happening all the time,
15 and sometimes that does mean reconfiguration
16 of services, it means redeploying workers
17 into different settings. Sometimes that has
18 to happen.

19 But if it happens in a planned way, to
20 make sure that the services are there for the
21 community, it also means we can retrain
22 people, put them in the settings that are
23 necessary, make sure that jobs are preserved
24 even if it's in a different context. And

1 that's what we'd like to see happen if we
2 need to reconfigure pieces of our healthcare
3 industry.
4 SENATOR JACKSON: Thank you.
5 CHAIRWOMAN KRUEGER: Thank you.
6 Anyone else? Thank you very much for
7 testifying today.
8 MS. SCHAUB: Thank you.
9 CHAIRWOMAN KRUEGER: Appreciate it.
10 The next up -- and I'm going to read a
11 few so that people can move down, because as
12 we get closer, you'll be closer. Next we
13 have Eric Linzer, Kathy Preston for New York
14 Health Plan Association. They'll be followed
15 by Community Health Care Association of
16 New York, Tiffany Portzer, followed by
17 Upstate New York Healthcare Coalition, Gary
18 Fitzgerald.
19 So again, if you move down closer, you
20 get right up front when you're called.
21 All right, and if there are two of you
22 speaking, know you're sharing five minutes.
23 MR. LINZER: Yes.
24 CHAIRWOMAN KRUEGER: So we always feel

1 bad for the second person, because usually
2 they get one minute. So just, you know, kick
3 him under the table, whatever's appropriate
4 for you. Did I just say that out loud? I
5 didn't say that out loud.
6 (Laughter.)
7 MR. LINZER: It's a hot mic, Senator,
8 so --
9 (Laughter.)
10 MR. LINZER: So good afternoon,
11 Assemblymembers, members of the Senate. For
12 the record, my name is Eric Linzer. I'm the
13 president and CEO of the New York Health Plan
14 Association. With me today is Kathy Preston,
15 HPA's executive vice president.
16 We appreciate the opportunity to offer
17 our testimony today with regard to the
18 proposed FY '20-'21 Executive Budget. Just
19 for context, we represent 29 health plans in
20 New York that provide comprehensive
21 healthcare services to nearly 8 million
22 New Yorkers.
23 We recognize the fiscal challenge the
24 state currently faces, but we remain

1 concerned with the ongoing cuts in Medicaid,
2 specifically to the health plans, which total
3 roughly about $800 million in cuts the last
4 three years. Our members have been
5 consistent, reliable partners in the state's
6 coverage expansion and delivery system reform
7 efforts and have been responsible stewards of
8 the state's funding around the Medicaid
9 program.
10 To protect the coverage and services
11 of the millions of New Yorkers who rely on
12 our member health plans in the Medicaid
13 space, we think closing the structural
14 deficit should focus, among other things, on
15 eliminating funding that doesn't meet the
16 goals of either expanding access or reforming
17 the delivery system, while rejecting any new
18 taxes or other measures that will increase
19 the cost of coverage for employers and
20 consumers.
21 Earlier this month HPA outlined a
22 comprehensive series of measures intended to
23 decrease the structural deficit by roughly
24 $900 million. Now, that's a start, we know

1 it doesn't get all the way. But these
2 proposals really focused on the goals of --
3 our funding mechanisms focused on reducing --
4 or increasing access to coverage, improving
5 quality or promoting delivery system reform.
6 Among the proposals we have were first
7 eliminating or substantially reducing certain
8 supplemental payment pools, which would
9 generate about $581 million in savings,
10 realigning the indigent care pool, which
11 would save about $138 million, and reforming
12 the health home program, which would save
13 about $150 million.
14 Now, we're not suggesting that this
15 money should go away, but it could be
16 reallocated into the Medicaid program to
17 ensure that the most vulnerable New Yorkers
18 continue to have access to the care that they
19 need.
20 In addition to that, our concern is
21 also that closing the gap should not result
22 in tax increases. New York currently
23 collects about $5 billion annually through
24 various taxes, surcharges and assessments on

1 health insurance through HCRA. I know this
2 has been talked about earlier today. Our
3 concern is any increase in those taxes only
4 makes it that much more difficult for
5 employers, consumers and unions to be able to
6 access and pay for high-quality affordable
7 coverage.
8 Now, there's been a lot talked about
9 the MLTC program, and I know we'll go into a
10 little more detail during Q&A. But we
11 believe that our member MLTCs have improved
12 the delivery of services, and they have
13 successfully controlled costs for the state.
14 Before MRT I, just to give some
15 perspective, personal-care spending in
16 fee-for-service grew by about 40 percent from
17 2003 to 2010, with the number of recipients
18 decreasing by about 15 percent. Today we've
19 seen a relatively stable increase in the PMPM
20 rate, but significant increases in
21 enrollment.
22 And some of this really has to do more
23 with, you know, some of the rules around what
24 the state has implemented and in some

1 instances have failed to implement. And we
2 think that there obviously needs to be more
3 detail dug into this issue, particularly as
4 it relates to fee-for-service.
5 Finally, with regard to some specific
6 proposals in the Governor's budget, we're
7 opposed to several sections in Part J. This
8 provision spells out a number of statutory
9 changes affecting health plan operations, and
10 we think that these provisions have no direct
11 financial impact on the State Budget.
12 Therefore, we don't believe that broad policy
13 proposals should be adopted in the budget,
14 especially without any real data to support
15 the necessity or impact, and would urge
16 rejection of Part J, which from what we've
17 been told was inadvertently -- many of those
18 provisions were inadvertently included.
19 Finally, we're generally supportive of
20 Part G, the Prescription Drug Pricing and
21 Accountability Board. And I know there's
22 been some conversation about the challenge
23 around prescription drug costs. Our concern
24 with it is while we appreciate the focus on

1 rising prescription drug prices, which are a
2 major challenge for both the commercial
3 market and the Medicaid space, our concern is
4 that the hundred percent threshold, the
5 doubling of a price, we think is too high a
6 bar and really needs to be lowered.
7 The state should not wait until a
8 price is doubled to take a look at whether or
9 not those price increases are justified, nor
10 should patients or consumers have to wait
11 until that level is hit. And we think that
12 manufacturers may in fact try and keep those
13 prices just below a doubling, which would
14 create certainly ongoing challenges around
15 keeping prescription drug costs controlled.
16 With that, we appreciate the
17 opportunity to testify and we'd be happy to
18 answer any questions you might have.
19 CHAIRWOMAN KRUEGER: Thank you. All
20 right, you got it in five minutes.
21 Anyone else? Gustavo Rivera.
22 SENATOR RIVERA: Good afternoon,
23 folks. Thank you for your patience.
24 A couple of things. Just because I'm

1 asking everybody on the record, have you been
2 approached by the administration to be part
3 of the MRT process?
4 MR. LINZER: No.
5 SENATOR RIVERA: Okay. And you have
6 on page 4 of your testimony -- and as you
7 were doing -- you know, quickly going through
8 part of it, you talked about in the area of
9 taxes, the sentence here is "We're especially
10 concerned by recent news reports the MRT will
11 consider raising taxes on health insurance as
12 a way to close the gap." So obviously your
13 position on that is clear.
14 Are you also opposed to a larger
15 conversation of generating revenue from
16 wealthier individuals?
17 MR. LINZER: I think the conversation
18 at the MRT -- the MRT shouldn't be charged
19 with trying to make decisions around tax
20 policy. I mean, that's, you know, something
21 that should be separate and apart from MRT.
22 MRT's focus should be on looking at
23 the structural challenges within Medicaid and
24 how do we get those costs under control.

1 SENATOR RIVERA: You were here when
2 Helen Schaub from 1199 testified just a
3 little bit ago, and I'm sure that you heard
4 some of the concerns that she has on behalf
5 of her union related to what they feel are
6 inducements, if you will, in the current
7 structures that have plans take advantage --
8 the words that they used were that they are
9 financially incentivized, right, that there's
10 financial incentive to just go and get more
11 folks and not necessarily provide the
12 services.
13 Do you share these concerns?
14 MS. PRESTON: No. The idea that
15 managed long term care plans are responsible
16 for Medicaid overspending is a red herring.
17 There's no financial incentive for plans to
18 enroll low utilizers. The rates are
19 risk-adjusted, so if you have a plan that has
20 gone and enrolled a large number of folks who
21 are low utilizers, their rate gets reduced
22 through a risk adjuster. That's how the
23 rates work, in order to reflect the fact that
24 some plans do have more folks who are higher

1 utilizers.

2 SENATOR RIVERA: Okay. And do you
3 have a position, an official position on the
4 cap and whether it should be revisited or
5 maintained?

6 MR. LINZER: I think with regard to
7 the cap, and similarly with issues within
8 MRT, it should certainly be on the table and
9 should be looked at and discussed, as should
10 also be looking at, as we mentioned in
11 testimony and our written remarks, you know,
12 some of the existing supplemental pools that
13 have been in place for years and decades, to
14 determine their necessity, their usefulness
15 and whether they're meeting the goals of
16 improving access, decreasing the number of
17 uninsured, and promoting delivery system
18 reform.

19 SENATOR RIVERA: Last, actually, very,
20 very last question, do you also share my
21 concern and the concern of some of my
22 colleagues that the timeline is exceedingly
23 small and short to be able to tackle such an
24 enormous problem?

1 MR. LINZER: And the short answer is
2 yes. I mean, I think as you've heard from
3 other folks, it's an aggressive time frame.
4 Plans were not -- you know, the association
5 was not part of the first MRT. But to that
6 end, we think it's going to be vitally
7 important that health plans and other
8 purchasers be part of that conversation and
9 not have it particularly provider-centric, as
10 it was the last go-round.
11 SENATOR RIVERA: Thank you so much.
12 Thank you, Madam Chair.
13 CHAIRWOMAN KRUEGER: Thank you.
14 Assemblymember Byrne.
15 ASSEMBLYMAN BYRNE: Yes, thank you
16 again for being here and being patient.
17 A similar question that I had for the
18 hospitals earlier. We've -- you know, you've
19 been speaking about the need for transparency
20 and balance for the Medicaid Redesign Team
21 II, MRT II. And we already know who the two
22 cochairs are, and they have background and
23 experience and affiliations, and we have a
24 lot of other stakeholders who are going to be

1 affected by this.
2 First of all, would you see the health
3 plans being a participant of that? And who
4 else -- what other advocates and groups
5 should be a part of that process?
6 MR. LINZER: So as the largest
7 statewide and most diverse health plan trade
8 association in New York, HPA would certainly
9 like to be part of that. And there should be
10 substantial plan representation, because
11 Medicaid has relied heavily on our industry
12 to -- you know, to -- around coverage
13 expansion and delivery system reform.
14 In addition to that, there should be a
15 broad and diverse group of individuals who I
16 think certainly -- who can provide
17 perspective. Among them should be the
18 state's actuary, Deloitte. Because as you
19 get into conversations about either potential
20 cuts or reductions, there needs to be a
21 meaningful conversation about actuarial
22 soundness around rates.
23 Second, there probably needs to be
24 some employer and purchaser participation on

1 there. Because if there's going to be a
2 conversation around taxes or assessments,
3 well, then there needs to be a conversation
4 of who pays for those.
5 And then finally, you know, it might
6 make sense to have some independent entities
7 who have been looking at this issue, whether
8 it be Citizens Budget or the Empire Center or
9 others who have been paying close attention
10 to this and can provide some independent
11 perspective on the challenges that the state
12 faces.
13 ASSEMBLYMAN BYRNE: Thank you. I
14 appreciate your remarks. And I would
15 actually agree with those recommendations.
16 And I think having a balanced, transparent
17 process -- we're already in a rushed
18 timeline, but having all stakeholders present
19 and participate I think is absolutely
20 crucial.
21 Thank you.
22 CHAIRWOMAN KRUEGER: Thank you.
23 Senator Diane Savino.
24 SENATOR SAVINO: Thank you,

1 Senator Krueger.
2 Good afternoon. Eric, you didn't read
3 your testimony, but I just want to point out
4 on page 2 is a pretty startling number that
5 you -- you talked about the growth of the
6 MLTC programs. I've spoken about it a few
7 times today, the growth in long-term care.
8 In your testimony you state that when
9 the CDPAP program was instituted in 2014, the
10 state spent $129.5 million on it. And as of
11 now, projected for FY 2021, it's 1.8 billion.
12 How did we get from $129 million to
13 1.8 billion?
14 MS. PRESTON: Right. Well, we've been
15 asking for those numbers for a while,
16 actually. I'm not sure we have a full
17 picture of what exactly has happened in
18 CDPAP.
19 So looking at some of just our MLTC
20 numbers, it grew from 83 million in 2014 to
21 1.9 billion. That's an increase of over
22 2,000 percent. I've never seen anything grow
23 at 2,000 percent. It was a policy of the
24 Health Department to expand the

1 Consumer-Directed Program. It's an important
2 tool to help folks who are eligible for it
3 remain in the community and independent.
4 SENATOR SAVINO: Right. We -- none of
5 us disagree with that.
6 MS. PRESTON: Right. But we have --
7 we raised -- the plans raised the flag on
8 this a couple of years ago and tried to have
9 some serious conversations about it.
10 Last year's budget included a couple
11 of provisions; one was to limit the number of
12 FIs in the program, and the other was, in
13 keeping with that, to change the
14 reimbursement to the FIs. The way they are
15 reimbursed drives additional hours, because
16 they get paid based on hours. So we
17 suggested, it was actually a plan suggestion,
18 to pay them that flat per-member per-month
19 rate, because then you take out that
20 incentive.
21 But there needs to be more
22 conversation about how this happened over
23 such a short period of time.
24 SENATOR SAVINO: It's extraordinary.

1 In five years, it's gone up -- I can't even
2 figure out the percentage. Somebody smarter
3 out there than me can figure it out. But
4 it's an extraordinary amount of money in a
5 relatively short period of time. And it just
6 defies logic that no one's really drilling
7 down into this to figure out how we got where
8 we are, because that there alone is more than
9 half of the budget deficit -- or the Medicaid
10 deficit.
11 MS. PRESTON: Right.
12 SENATOR SAVINO: Thank you.
13 CHAIRWOMAN KRUEGER: Thank you.
14 Assembly.
15 CHAIRWOMAN WEINSTEIN: Assemblyman
16 Cahill.
17 ASSEMBLYMAN CAHILL: Hi. Thanks,
18 folks, and thanks for being here. Just a
19 couple of quick questions, first about EI.
20 The Governor has proposed that you do
21 pay-and-pursue when it comes to Early
22 Intervention. Can you give me your thoughts
23 on that proposal?
24 MR. LINZER: So I think we understand

1 the state's desire to try and reduce some of
2 the costs on the municipalities. I heard the
3 conversation earlier today, and some of your
4 comments, Mr. Chairman.
5 I think our concern becomes when we
6 start, similar to -- and this shouldn't be
7 any surprise -- shifting additional or other
8 state or county costs onto the commercial
9 market, you know, only is going to lead to
10 higher health insurance premiums. I think to
11 your point earlier, about this has been an
12 ongoing issue that you've looked at and have
13 raised in the past, and maybe it's high time
14 to really pull some of the folks involved in
15 this together to have a meaningful
16 conversation separate and apart from the
17 budget dialogue, to see what the issues are
18 and how best to address this.
19 ASSEMBLYMAN CAHILL: So you wouldn't
20 be opposed to doing something other than
21 finding out who does the pursuit for payment?
22 MR. LINZER: I think we'd want to have
23 a -- you know, I think -- I'm not suggesting
24 that we may support other approaches, but I

1 think, you know, this one in particular is,
2 you know, merely just shifting costs from one
3 entity to another and doesn't get at what the
4 underlying drivers are here.
5 ASSEMBLYMAN CAHILL: Am I hearing you
6 say that you're opposed to the Governor's
7 pay-and-pursue?
8 MR. LINZER: Oh, yeah. Yes.
9 ASSEMBLYMAN CAHILL: I just want to
10 make sure --
11 MR. LINZER: Oh, yes. Yup.
12 ASSEMBLYMAN CAHILL: I didn't know
13 that -- I went through your written testimony
14 but I didn't see it there.
15 So the other question that's coming up
16 and it's kind of lingering out there is what
17 happens to insurance plans if a decision is
18 made that somehow or another a good way to
19 fill the gap without impacting beneficiaries,
20 as they were called -- they're actually
21 called recipients, under the law -- for
22 Medicaid, and without going after our local
23 governments to pay more. There's only a
24 couple of other places to go, and guess what?

1 You're one of them.

2 What if that were to come to pass?

3 What impact would that have on ratepayers in

4 New York State for health insurance?

5 MR. LINZER: Well, we are taking a

6 look at what the impact would be on premiums.

7 But depending upon what the number is, or

8 regardless of what the number is, any amount

9 of the 2.5 billion shifted onto the private

10 market, either through increased HCRA taxes

11 or other taxes, is going to lead to higher

12 health insurance premiums.

13 And I think the challenge here is that

14 to ask the private commercial market,

15 employers and consumers and unions, to have

16 to fill the gap in the state -- with the

17 state unable to manage its Medicaid costs,

18 just seems to be unfair to those individuals.

19 That said, part of the reason why we

20 outlined what we did a couple of weeks ago,

21 around ways to close the gap, is at a time

22 when you're facing a $2.5 billion deficit, or

23 whatever the number may be -- you know,

24 resources are finite, they're limited, and we

1 need to make sure that we're making the best
2 use of those dollars. So as we outlined,
3 there's a number of supplemental payment
4 pools that have been around for years, and in
5 some instances decades, that sort of begs the
6 question, why are they necessary?
7 There was a conversation earlier today
8 about the medical malpractice pool. I think
9 if the issue here is, you know, if medical
10 malpractice is a challenge regardless of why
11 the pool is there, is it meeting the goals of
12 what we should be doing in Medicaid, which is
13 making sure people have coverage, reforming
14 the delivery system, and improving quality.
15 So there's a number of pools that
16 we've outlined -- you know, medical
17 malpractice is one, recruitment and
18 retention. There's dollars there. We're not
19 suggesting taking away --
20 ASSEMBLYMAN CAHILL: We're down to the
21 last minute, and I swore I wasn't going to
22 take the whole time. But -- so the answer to
23 the question is you think there are other
24 places to go than doing some sort of

1 assessment against insurance companies to pay
2 for it.
3 MR. LINZER: Oh, absolutely.
4 ASSEMBLYMAN CAHILL: So my last
5 question to you is there has been some talk,
6 not very formal, not very deep, about
7 instituting a state individual mandate. Does
8 the group have an opinion on that?
9 MR. LINZER: Yeah, we'd be supportive
10 of an individual mandate. I think --
11 ASSEMBLYMAN CAHILL: That's good, we
12 can stop there. That's good. Thanks. Bye.
13 (Laughter.)
14 CHAIRWOMAN WEINSTEIN: Senate?
15 CHAIRWOMAN KRUEGER: Robert Jackson.
16 SENATOR JACKSON: Thank you for coming
17 in. Appreciate you. So I was listening
18 to -- I thought I heard you say, and correct
19 me if I'm wrong, that -- basically that you
20 didn't see taxes would -- increasing taxes
21 would help this situation.
22 MR. LINZER: I think what I said was
23 two things. One, taxes would -- and
24 particularly in the health insurance space,

1 is going to exacerbate the challenge of
2 affordability for employers and consumers.
3 SENATOR JACKSON: Okay, hold it right
4 there. You said impact affordability. But
5 taxes -- if we talk about revenue, asking
6 those that are millionaires or above, it's
7 not going to impact 99 percent of the people
8 that have health insurance. You know what
9 I'm saying. Do you agree with that or
10 disagree?
11 MR. LINZER: Senator, I think we're --
12 you know, the context in which I'm discussing
13 is around HCRA taxes. And the fact is we've
14 got -- we -- you know, there are 5 -- and
15 this was brought up a number of times today,
16 but $5 billion in taxes imposed on health
17 insurance only exacerbates the challenge that
18 employers and consumers and unions and others
19 face in paying for health insurance,
20 regardless of what your income level is.
21 So on the private marketplace it
22 does -- you know, it does create real
23 challenges for individuals who are trying to
24 pay the monthly premium.

1 SENATOR JACKSON: But -- but -- okay,
2 so if -- basically, I guess if I'm looking at
3 you, you're opposed to raising revenue to
4 deal with this particular matter. That's
5 what I'm seeing. No matter what you're
6 saying, that's what you -- the vibes you've
7 given off to me. And if that's the case,
8 then we're going to either have to shrink
9 what currently exists in order to fit within
10 that monetary pot that we have, or do
11 reductions and shrinkage. And that is going
12 to be devastating on the people that we
13 represent.
14 MR. LINZER: But Senator, as I
15 mentioned, there's a number of supplemental
16 payment pools that, you know, ought to be
17 looked at and determine whether or not
18 they're really necessary. Now, I'm not
19 suggesting we take all that money away. That
20 money certainly could be reallocated within
21 the Medicaid program to shrink the gap and
22 minimize some of the challenges.
23 The Indigent Care Pool is, you know,
24 certainly an example where, you know, you've

1 got certain hospitals that, you know, may see
2 a small number of low-income uninsured
3 individuals but still -- you know, and have
4 substantial margins and don't really need the
5 funding. As opposed to other institutions
6 that, you know, are the backbone of the
7 indigent care system to be -- and aren't
8 getting sort of really, you know, sufficient
9 funding.
10 So I think -- you know, I emphasize
11 that when you look at some of these pools,
12 you know, at a time when you're dealing with,
13 you know, a significant budget deficit, some
14 of the focus needs to be on reforming how we
15 spend those dollars.
16 SENATOR JACKSON: Thank you.
17 CHAIRWOMAN KRUEGER: Thank you.
18 Thanks for your testimony today.
19 Our next up is Community Health Care
20 Association of New York State, come on up.
21 And then for people getting closer, we have
22 Upstate New York Healthcare Association, then
23 the New York State Association of County
24 Health Officials.

1 MS. PORTZER: Hello.
2 CHAIRWOMAN KRUEGER: Hello.
3 MS. PORTZER: I was going to say --
4 this morning I wondered would I say good
5 morning or good afternoon, and now I think
6 it's good evening, actually.
7 (Laughter, overtalk.)
8 MS. PORTZER: All right, I'll go with
9 good afternoon. And thank you for the
10 opportunity to provide testimony on the
11 Governor's budget proposal. I'm Tiffany
12 Portzer, vice president of communications at
13 the Community Health Care Association of
14 New York State, better known as CHCANYS. Our
15 president and CEO, Rose Duhan, apologizes for
16 not being here today; she had a prior
17 out-of-state commitment.
18 A little bit about us. CHCANYS is
19 the voice of New York's 70 community health
20 centers, CHCs for short, which provide
21 comprehensive primary care services at more
22 than 800 sites statewide to 2.4 million
23 New Yorkers, regardless of their immigration
24 status, insurance coverage, or ability to

1 pay. That's one in eight New Yorkers we
2 provide care for.
3 You have our written testimony, but I
4 want to hit a few key points in my oral
5 testimony today.
6 First, PCMH. CHCANYS respectfully
7 requests that the Legislature ensure that the
8 PCMH program funding is protected at 2019
9 levels at a minimum -- New York State has
10 identified the patient-centered medical home
11 model as the gold standard of comprehensive
12 primary care -- and, through DSRIP, to
13 incentivize providers to participate in the
14 program. Ninety-three percent of New York
15 health centers are PCMH-certified and CHCANYS
16 estimates that CHCs received more than
17 $56 million in PCMH incentive payments in
18 2019.
19 Studies have found that individuals
20 who saw primary care physicians at
21 PCMH-certified sites had fewer specialty
22 visits and 14 percent lower per-patient costs
23 when compared to individuals seen at other
24 primary care providers. Nationally,

1 PCMH-enrolled individuals are less likely to
2 receive care in an emergency department when
3 compared to non-PCMH-enrolled individuals.
4 Funding for the PCMH program is a
5 crucial investment in high-quality,
6 comprehensive primary care practices. Any
7 reduction to PCMH funding will directly
8 impact health centers' ability to continue to
9 provide coordinated care management services
10 and to prepare for and engage in value-based
11 payment arrangements.
12 For the past two years, thanks to your
13 efforts, PCMH funding has remained stable,
14 providing critical support for community
15 health centers and other primary care
16 providers. We ask that you continue your
17 support of this important program and support
18 level funding for PCMH.
19 Second, CHCANYS requests that the
20 Legislature dedicate 40 percent of future
21 DSRIP funds directly to community-based
22 providers, including community health
23 centers, behavioral health providers, home
24 care, and hospice providers. In November

1 2019, the state submitted a proposal to CMS
2 requesting $8 billion to implement a new
3 DSRIP program, DSRIP 2.0, which would run
4 from April 2020 to March 2024. CHCANYS
5 applauds the state's work in the first round
6 of DSRIP to reduce costs, improve patient
7 outcomes, and decrease unnecessary inpatient
8 and emergency room utilization.
9 Community health centers were leads or
10 key partners in achieving many of the
11 benchmarks. However, the first round of
12 DSRIP had no specific requirements about how
13 funds flow to partners in the PPS networks.
14 And as a result, the amounts received by CHCs
15 varied.
16 For New York State to experience a
17 real transformation of the healthcare
18 delivery system, and sustain the gains thus
19 far achieved through DSRIP, there must be a
20 significant direct investment in
21 community-based care. CHCs' delivery of
22 advanced comprehensive primary care has led
23 directly to the successful achievement of
24 DSRIP's primary goals, reducing avoidable

1 hospitalizations and inappropriate
2 presentations at emergency rooms.
3 CHCANYS thanks the Legislature for
4 your ongoing support of community-based
5 providers and requests that you mandate that
6 at least 40 percent of any future DSRIP funds
7 be allocated directly to community-based
8 providers, including CHCs.
9 Third, CHCANYS urges the Legislature
10 to maintain the diagnostic and treatment
11 centers safety-net pool at current funding
12 levels. The Governor and Legislature have
13 historically supported funding for the
14 safety-net pool to help cover CHCs' cost of
15 caring for the uninsured, which makes up
16 16 percent of patients. As in prior years,
17 this year's Executive Budget includes
18 $54.4 million in state funding, which would
19 draw down an equal federal match. The
20 funding partially reimburses CHCs for the
21 cost of caring for the uninsured, the rate of
22 which is three times higher at CHCs than in
23 the general New York State population.
24 However, at some health centers -- get

1 this -- more than half of the patients are
2 uninsured.
3 The funding is particularly important
4 in light of the recent Supreme Court decision
5 to allow the public charge rule to take
6 effect nationwide. Although the rule only
7 applies to a small percentage of legal
8 immigrants, the chilling effect is expected
9 to be widespread. Health centers have
10 already reported patients choosing to
11 disenroll in Medicaid for fear of immigration
12 actions. The safety net funding is a
13 critical resource to help cover the cost of
14 caring for the uninsured, which we anticipate
15 could rise due to ongoing fears in the
16 immigration community.
17 Finally, I wanted to quickly address
18 the Governor's proposal to reconvene the MRT,
19 which is something we've obviously heard a
20 lot about today. It is imperative that MRT
21 include representation from community-based
22 providers and Medicaid consumers, including
23 community health centers and our
24 representatives. We urge the Legislature to

1 ensure that the MRT and budget process is
2 transparent and accounts for the full
3 spectrum of New York's healthcare system.
4 I thank you for your time today, and
5 for giving us the opportunity to testify, and
6 I'm happy to answer any of your questions.
7 CHAIRWOMAN KRUEGER: Thank you.
8 SENATOR JACKSON: Whoo! (Applauding.)
9 MS. PORTZER: And I made it!
10 CHAIRWOMAN KRUEGER: Gustavo Rivera.
11 SENATOR RIVERA: (imitating
12 auctioneer) Sold!
13 (Laughter.)
14 MS. PORTZER: I was listening to you
15 earlier, and I was like, we're in a run for
16 each other's money here.
17 SENATOR RIVERA: That is fantastic.
18 First of all, I thank you for being
19 the first -- the first -- and I know we have
20 a lot of folks to go, but the first
21 organization or representative of an
22 organization to mention the public charge. I
23 had the opportunity to talk very briefly --
24 MS. PORTZER: I'm having a little bit

1 of a hard time hearing you, sorry.
2 SENATOR RIVERA: I am thankful that
3 you referred to the public charge rule and
4 the impact that it would potentially -- that
5 it will have on the state.
6 MS. PORTZER: It's already having.
7 SENATOR RIVERA: Right, we're just
8 trying to figure out how deep that impact is
9 going to go. It was -- I had a brief part of
10 the conversation that I had with the
11 Department of Health and the Medicaid
12 Director this morning when I mentioned it
13 right at the end of their testimony.
14 But it's obviously something that
15 we're going to have to deal with, because as
16 you said, we're -- it's impacting us now.
17 And you also -- I was surprised that
18 you hadn't mentioned anything about the MRT.
19 You did towards the end, and so as I did with
20 everybody else -- I think I know what the
21 answer is -- but has your organization been
22 officially asked or contacted by the
23 administration to be part of the MRT process?
24 MS. PORTZER: (Shaking head.)

1 SENATOR RIVERA: Could you say it,
2 please?
3 MS. PORTZER: No.
4 SENATOR RIVERA: There you go.
5 because we need it for the record.
6 So the -- and would you -- do you have
7 a position on the cap, since there has been a
8 conversation about it?
9 MS. PORTZER: Not speci -- we just
10 want to be part of any conversations that are
11 happening.
12 SENATOR RIVERA: Gotcha. So does that
13 mean that you're supportive of keeping the
14 cap in place or --
15 MS. PORTZER: It's not a conversation
16 that I've had with my colleagues at this
17 point, so it's not really something I can
18 answer right now. But any ongoing
19 conversations, we want to be part of.
20 Community health centers I think sometimes
21 get left out of the conversation --
22 SENATOR RIVERA: Yes, ma'am.
23 MS. PORTZER: We want a seat at the
24 table, us and consumers of Medicaid and

1 consumers of healthcare.
2 SENATOR RIVERA: Understood and
3 agreed.
4 And the -- related to -- and I figure
5 that you have -- I'm also asking folks about
6 the timing and whether the timing that we're
7 dealing with is realistic. So just do you
8 have an opinion on that from the perspective
9 of the community health centers?
10 MS. PORTZER: Anything is realistic.
11 Again, all I'll say is we want a seat at the
12 table as the conversations progress.
13 SENATOR RIVERA: Thank you so much.
14 MS. PORTZER: Thank you.
15 SENATOR RIVERA: Thank you, Madam
16 Chair.
17 CHAIRWOMAN KRUEGER: Thank you.
18 Assembly? Any other Senators? Then
19 thank you very much for being here today.
20 MS. PORTZER: Thank you very much.
21 CHAIRWOMAN KRUEGER: So our next
22 testifier is Upstate New York Healthcare
23 Coalition, Gary Fitzgerald.
24 Then for people who are watching to

1 get ready to be on deck, we'll then next have
2 the New York State Association of County
3 Health Officials -- three people in five
4 minutes, fight it out in the hall quick --
5 then Feeding New York State.
6 Good evening.
7 MR. FITZGERALD: Good evening.
8 CHAIRWOMAN KRUEGER: Afternoon. Still
9 afternoon.
10 MR. FITZGERALD: Is this on? Yes, it
11 is.
12 Thank you, Chairs Krueger and
13 Weinstein, Gottfried and Rivera, and the rest
14 of the legislators. Thank you very much for
15 the opportunity to listen and to speak
16 briefly. I'm going to sum up my summary, so
17 I won't take long.
18 I'm here really to talk about the
19 Upstate Healthcare Coalition. It's a group
20 of hospitals and healthcare systems from
21 Albany down to Columbia County and over to
22 Buffalo. We got together last year to make
23 sure that the needs and the specific issues
24 related to upstate healthcare providers are

1 made apparent to you. And I will --
2 Senator Ritchie teed me up for my remarks
3 about the upstate hospitals earlier today.
4 The upstate hospitals face different
5 issues than downstate hospitals. And it's
6 not bad or good, it's just different. We
7 have a different payer mix, we have high
8 Medicare, lower Medicaid, older patients,
9 sicker patients. We have geography problems
10 that you talked about. And we have a huge
11 workforce shortage across upstate New York.
12 Not just in physicians, but in every worker
13 area in the healthcare industry, we have
14 shortages. So I'd like to comment about
15 that.
16 As far as our -- we have 34 -- 35,
17 excuse me, communities in upstate New York
18 that have one hospital in that community.
19 Those are called sole community hospitals or
20 critical access hospitals. That means if
21 that hospital goes down or becomes converted
22 into an emergency room, like has happened in
23 a number of our communities, those hospitals
24 also employ the doctors in that community, so

1 those doctors will probably leave the
2 community if that hospital closes and is
3 converted into something less than a
4 hospital.
5 And we're not asking for all the
6 hospitals in upstate New York to have all the
7 technology and all the services. As you
8 mentioned, Senator, we have downsized over
9 the years; we just need the basic services,
10 and I think the citizens of upstate New York
11 deserve those basic healthcare services in
12 their communities.
13 As far as funding goes, 85 percent of
14 the hospitals in upstate New York lost money
15 in 2017. Those are the last numbers that we
16 have. Eighty-five percent had a negative
17 margin. The average margin in upstate
18 hospitals is minus 4.3 percent. So to the
19 comments earlier, I think it was Assemblyman
20 Cahill and others, there's just no way that
21 you can absorb additional cuts to the
22 magnitude of 2.5 billion, or whatever the
23 number ends up being, without seeing services
24 eliminated and some hospitals closing.

1 And as I said, the trend is a hospital
2 one day, an emergency room the next day. And
3 that's just not fair for some of our
4 communities.
5 And if you want to talk about business
6 development, what business in their right
7 mind would ever come to an upstate community
8 that has just closed its hospital and it's
9 very difficult to get a doctor's appointment
10 in that community?
11 That's why we'd urge you to consider,
12 and we've made this clear to the Governor and
13 his staff, that the hundreds of millions of
14 dollars in economic development that the
15 Governor has put into upstate communities,
16 it's a great thing -- but we've tried to get
17 them to just take a little bit of that money
18 and use it for workforce development in
19 upstate communities -- healthcare workforce
20 development. Whether it's loans, loan
21 forgiveness, continue to expand those
22 programs, training, recruitment, retention --
23 we're doing all that through our association,
24 but we cannot break through the economic

1 development funding sources to explain that
2 without healthcare systems in upstate
3 New York, you will not get economic
4 development in those communities.
5 We do have, as I said, a workforce
6 shortage. We have 2,000 vacancies from
7 Buffalo to Albany in the hospital inpatient
8 setting of RNs. So when we talk about nurse
9 staffing ratios, which was mentioned, again,
10 earlier today, it's very hard for us to
11 understand how we could fill those vacancies
12 with the mandated staffing ratio bill that's
13 being discussed. We don't have the money and
14 we don't have the nurses. So unless there's
15 some major issues changing in education,
16 training, and the recruitment and retention
17 of those RNs, there's no way that that bill
18 would be enforceable in upstate New York. Or
19 else you just close the facilities and their
20 services.
21 I'll leave you with this quote -- or
22 this statistic that we found a couple of
23 weeks ago in a New York Times article: Over
24 100 rural hospitals have closed across the

1 country over the last 10 years, including, as
2 I said, several in upstate New York. We
3 don't want to see this trend continue.
4 And this Medicaid cut coming is --
5 obviously would continue that trend in
6 upstate New York. And for all the reasons
7 that I've said earlier -- you lose those
8 hospitals, you lose those doctors, in some
9 cases you lose the nursing home that's
10 attached to that hospital. And that would be
11 devastating for these upstate communities.
12 So I will work with you, we will work
13 with the MRT. Quite frankly, before you ask
14 the question, Senator, I have not been asked
15 to serve on the MRT by the administration.
16 (Laughter.)
17 MR. FITZGERALD: But we will do
18 whatever we can do in the next 60 days to
19 make it happen.
20 One thing that I will point out, in
21 2017 we passed -- you passed. We passed? --
22 Chapter 419 of the Laws of 2017, which
23 created the Rural Health Council. It has
24 members from each house and the Governor's

1 appointments. That was put together with our
2 staff, trying to figure out ways to get a
3 New York State rural health plan in place.
4 No appointments have been made by the
5 Governor. No meetings of the Rural Health
6 Council since 2017 have been -- have taken
7 place.
8 So good legislation, thank you for
9 passing it in both houses, he signed it, but
10 we still don't have a Rural Health Council
11 put in place. Now would be a great time for
12 that, quite frankly. And it could meet on a
13 regular basis for more than just 60 days so
14 we could figure out some of the problems that
15 I've brought up today.
16 So with that, I'm done.
17 CHAIRWOMAN KRUEGER: Thank you.
18 Any questions from the Senate? Pat
19 Ritchie. Oh, I'm sorry. Senator Rivera, the
20 Health chair.
21 SENATOR RIVERA: You already answered
22 my first one, thank you for that.
23 Do you have an official position on
24 the cap?

1 MR. FITZGERALD: Yes, the cap needs to
2 be looked at, reexamined. It needs --
3 probably needs to be raised, quite frankly.
4 It's 10 years old, so it needs to be looked
5 at.
6 SENATOR RIVERA: All right. Thank
7 you, sir.
8 CHAIRWOMAN KRUEGER: Assembly, any?
9 (Off the record.)
10 CHAIRWOMAN KRUEGER: Senator Pat
11 Ritchie.
12 SENATOR RITCHIE: I just want to say
13 thank you for partnering with me in the past
14 to do the take-a-look tour. That was
15 something I think was beneficial. Hopefully
16 we can do that again.
17 You answered most of my questions
18 during your five minutes. I would just like
19 to ask, as far as -- we started off with a
20 doctor shortage and then a shortage in
21 nurses. The nursing shortage seems to be
22 getting even worse pretty much by the day.
23 Do you have any idea with regards to the
24 doctor shortage, is that maintaining, or both

1 of them increasing exponentially?
2 MR. FITZGERALD: Well, we see them
3 increasing, quite frankly -- aging out of the
4 workforce, with the nurses and doctors as
5 well, burnout, all the issues we talked
6 about.
7 And we just actually -- not signed it
8 yet, but we're in the process of dealing with
9 the Empire State College to connect their
10 online training for nurses and CNAs and
11 others with our hospitals and the vacancies
12 that we have. So we're doing what we can to
13 try to increase training and education for
14 CNAs and nurses. That's really a main
15 problem.
16 Some of the problems in the rural
17 areas, you can't get enough nurses to do the
18 training. They're either retired or they
19 don't want to be part of it or it's not --
20 we're not paying them enough to do the
21 training.
22 So we're working -- it's -- the
23 problem is getting worse, but we're trying to
24 experiment with different ways to make it

1 better. We even just recently signed an
2 agreement with St. George's University in
3 Grenada to bring some of their medical
4 students into upstate New York so that
5 hopefully they train here and they stay here.
6 And so we're pulling out all the stops.
7 We'd like to do another round of tours
8 if we can get some funding for that, Senator.
9 It's exposing downstate students and
10 residents to the upstate New York healthcare
11 system. And when they get here, they can't
12 believe we actually have technology and
13 running water sometimes.
14 (Laughter.)
15 SENATOR RITCHIE: I'd just like to
16 finish by saying I appreciate you talking
17 about how dire the situation is. I know
18 earlier I brought up how many times I've
19 gotten calls from hospitals and nursing homes
20 in my last nine years, and it's pretty much
21 on a weekly basis. So we really are in a
22 critical situation.
23 MR. FITZGERALD: Well, and I know we
24 have a number of hospitals today that are

1 under that 15-day cash-on-hand number, and
2 they're in upstate New York. So that's a
3 serious sign.
4 CHAIRWOMAN KRUEGER: Thank you very
5 much. Appreciate you being here.
6 Oh, stay where you are. Senator
7 Seward.
8 SENATOR SEWARD: Thank you.
9 Gary, I just wanted to say -- there is
10 a question coming, but I just wanted to say
11 that I've appreciated your work over the
12 years and your organization and your staff
13 and member hospitals for highlighting the
14 needs of our upstate hospitals, particularly
15 in the rural parts of our state. And I know
16 you represent a mix in terms of some of the
17 larger cities upstate.
18 But there are special challenges in
19 terms of operating a hospital in the more
20 rural parts of our state, as Senator Ritchie
21 has pointed out. And we really do need to
22 recognize that, because if a hospital closes
23 in a rural community, not only is it
24 devastating for that community, there may be,

1 you know, 40, 30, 50 miles to the next
2 available hospital.
3 MR. FITZGERALD: That's right.
4 SENATOR SEWARD: I mean, so you
5 have the distances -- very bad for the people
6 of that region.
7 My question is, I know you got a Happy
8 New Year good wishes with that 1 percent --
9 MR. FITZGERALD: New Year's Eve.
10 SENATOR SEWARD: -- New Year's Eve,
11 announced for the hospitals and health
12 systems, an across-the-board 1 percent cut in
13 Medicaid.
14 MR. FITZGERALD: Yes.
15 SENATOR SEWARD: Now, that totals
16 $500 million annually?
17 MR. FITZGERALD: When you annualize it
18 out, yes, with the federal share, yes.
19 SENATOR SEWARD: Would it be your
20 position, shall we say, in terms of actual
21 cuts in Medicaid payments, you've already
22 contributed?
23 MR. FITZGERALD: We've already given
24 at the New Year's Eve party. And that should

1 be included. Remember, that -- the
2 Governor's budget doesn't roll that through
3 2020-2021. So yes, we've already given. And
4 it -- it -- continuing to cut Medicaid, as I
5 said, in upstate New York it only pays
6 69 cents on the dollar now, so you just
7 continue to --
8 SENATOR SEWARD: Right. Well, I think
9 that's an important point to raise as they
10 look at another $2.5 billion in savings:
11 Looking to further cuts in some of these
12 struggling hospitals and other health systems
13 is not the answer.
14 Thank you.
15 MR. FITZGERALD: Thank you.
16 CHAIRWOMAN KRUEGER: Thank you. Now
17 we're going to let you off. Thank you very
18 much, Gary.
19 Next up, New York State Association of
20 County Health Officials. I see perhaps two,
21 not three.
22 Hi. Evening.
23 DR. GUPTA: Good afternoon, Senator
24 Rivera, Assemblymember Gottfried, Senator

1 Krueger, Assemblymember Weinstein, and
2 distinguished committee members. Thank you
3 for this opportunity to provide testimony on
4 the 2020-2021 Executive Budget.
5 My name is Indu Gupta. I am
6 commissioner of health in Onondaga County, in
7 central New York, and I'm here to represent
8 the New York State Association of County
9 Health Officials, known as NYSACHO, as a
10 member of the board of directors, along with
11 NYSACHO's executive director, Sarah
12 Ravenhall.
13 NYSACHO understands the imperative of
14 closing the state's budget gap. We
15 appreciate that the proposed budget did not
16 contain any cuts in critical public health
17 funds. However, we are concerned that the
18 proposal did not include a long-requested
19 increase in Article VI funding which supports
20 the core public health local health
21 departments do every day.
22 Public health departments are
23 dedicated to improve and protect health of
24 people and their communities where they are

1 born, live, learn, work and play. You may
2 have heard of the phrase "Our zip code is a
3 better predictor of our health than our
4 genetic code," because the factors we call
5 social determinants of health impact
6 80 percent of the health outcomes of a
7 person, and cumulatively health of the
8 communities.
9 So what do local health departments
10 do? We continue to monitor and mitigate the
11 reemergence of all communicable diseases such
12 as vaccine-preventable hepatitis A, measles,
13 virus infections, to the very recent
14 unfolding of the novel coronavirus infection
15 in the United States imported from China, to
16 any new public health threat on the horizon
17 within the country, such as vaping.
18 At the same time, we remain dedicated
19 to much-needed work to reduce lead exposure
20 to protect the health of children, home
21 visits to check on moms, babies and dads, and
22 provide support services during early
23 childhood by the Early Intervention program.
24 We continue to work to keep our

1 environment safe through restaurant
2 inspections, ensuring water safety,
3 performing camp inspections, and the list is
4 long. We continue to work quietly in the
5 background with only one laser-focused goal:
6 Keeping our communities safe and healthy.
7 Imagine the impact of lack of any of
8 these services in our respective communities.
9 Can we as a society afford it? The answer
10 certainly is no.
11 In our comprehensive written testimony
12 submitted for your review, we respectfully
13 ask and urge you and your staff to please
14 carefully consider the priorities and
15 concerns articulated within it. Due to the
16 time constraint, I'll bring your attention to
17 three specific areas.
18 One, NYSACHO continues to strongly
19 oppose adult-use cannabis, based on science
20 and experiences in other states, which has
21 shown that it adversely impacts health, both
22 at an individual and societal level.
23 However, if the state proceeds with the
24 program, we ask that local public health

1 officials, who are the chief health
2 strategists of the communities, have a
3 concrete role in steering cannabis policies
4 and should be provided additional resources
5 for surveillance and education.
6 Number two, to ensure effective
7 implementation of the important work to
8 reduce childhood exposure to lead, we urge
9 that the state allocate $46 million to cover
10 the full cost of the expanded mandate.
11 Number three is we also ask that the
12 local health departments play a key role in
13 the state's Medicaid redesign initiative with
14 MRT II or DSRIP 2.0, because local health
15 Departments are the bridge between healthcare
16 and the community.
17 Thank you for your continued support
18 of public health by supporting the work of
19 local health departments. We are happy to
20 address any questions you may have.
21 CHAIRWOMAN KRUEGER: Thank you.
22 Senators?
23 SENATOR RIVERA: Do you, as an
24 organi -- first of all, thank you for being

1 here and thank you for your patience. Has
2 your organization been approached by the
3 administration to participate in the MRT
4 process?
5 MS. RAVENHALL: We submitted formal
6 correspondence to the Governor's office
7 requesting a seat at the table because we
8 think it's imperative and critical local
9 health departments play a role in MRT II/
10 DSRIP reform initiatives.
11 And to answer your question, the
12 answer is no, we have not received a
13 subsequent formal invitation or designated
14 role in that initiative.
15 SENATOR RIVERA: What is the position
16 of your organization on the Medicaid cap?
17 MS. RAVENHALL: We don't have a formal
18 position on the Medicaid cap. Anything that
19 impacts county government impacts local
20 health departments, and so it's something we
21 work closely with NYSAC on and keep an eye
22 on. It's certainly something that we are
23 concerned about.
24 SENATOR RIVERA: And I'm sure that

1 you're also concerned about the potential
2 reorganization of the local share that's
3 being spoken about, the 2 percent, 3 percent
4 thing. Right?
5 In the organization of county health
6 officials, I figure -- how many -- do you
7 have every county that's not the City of
8 New York?
9 MS. RAVENHALL: We represent all
10 jurisdictions, so we include New York City in
11 that.
12 SENATOR RIVERA: Including New York
13 City.
14 MS. RAVENHALL: Yes. We represent New
15 York City.
16 SENATOR RIVERA: Gotcha. So
17 there's -- so you have representation of the
18 62 counties in your organization.
19 MS. RAVENHALL: Yes.
20 SENATOR RIVERA: And so then you're
21 probably -- well, besides obviously the
22 administration, you would probably be the
23 best to provide data that actually comes from
24 the analysis within those counties about

1 whether they are -- whether they would be
2 impacted by the proposal that we have in
3 front of us. I'm sure that you have heard
4 from them. I know that I've only heard from
5 a few. I mean, the City of New York has its
6 estimate, which is enormous, but obviously it
7 is an enormous locality. But I've heard from
8 Westchester County and -- I know one of my
9 colleagues heard from an upstate county, and
10 I can't recall the number -- or I can't
11 recall the county itself. But I figure
12 you've heard from most counties.
13 Do you have a sense -- even though the
14 administration could not tell us this morning
15 when we asked them directly, and we have
16 asked them before, Can you provide us
17 information on what counties would be
18 impacted by this proposal? And they couldn't
19 tell us. I figure you probably have a better
20 idea.
21 MS. RAVENHALL: I don't have the data
22 on hand, but I'd be happy to get it to you
23 after this hearing.
24 SENATOR RIVERA: Yes.

1 MS. RAVENHALL: And then, you know,
2 something else that we're concerned about is
3 the Article VI funding, and specifically the
4 cut that was implemented last year to the
5 New York City Department of Health and Mental
6 Hygiene.
7 Any threatened cuts to Article VI
8 concerns, you know, all of our membership
9 because it's kind of the bread and butter of
10 local health departments and how we're
11 funded. A lot of times residents will work
12 in Manhattan and live in Westchester, work in
13 Queens and live in Nassau County. And so
14 public health impacts everybody and the work
15 that the New York City Department of Health
16 and Mental Hygiene does is really critical in
17 that Article VI.
18 SENATOR RIVERA: So I would
19 appreciate -- we would appreciate, as a
20 Legislature, those numbers, because since
21 apparently the administration doesn't want to
22 give it to us, then we could at least -- and
23 I know that some of my colleagues have
24 already heard from particular counties that

1 have approached them. But it is likely that
2 you have a better network, right, because
3 they all -- you have -- you probably have a
4 little phone tree that --
5 MS. RAVENHALL: Senator, I'd be happy
6 to get back to you after this hearing,
7 absolutely.
8 SENATOR RIVERA: And -- but even
9 though you might not have the data in front
10 of you, the conversations that you've had
11 with county health officials that have
12 reached out to you -- because I'm sure many
13 of them have -- have there been any of them
14 that say, like, we're fine, we're going to be
15 fine?
16 MS. RAVENHALL: No, it will impact
17 everyone, all of our counties.
18 SENATOR RIVERA: Right. Thank you so
19 much for being here.
20 Thank you, Madam Chair.
21 CHAIRWOMAN KRUEGER: Assembly?
22 CHAIRWOMAN WEINSTEIN: No, we're all
23 through.
24 CHAIRWOMAN KRUEGER: Senator Jackson,

1 did you have a question?
2 SENATOR JACKSON: Thank you. I'm just
3 curious, I mean, obviously I've skimmed
4 through this. You talked about Article VI
5 and you say that's the bread and butter of
6 the county health departments. And
7 obviously -- I'm glad that you mentioned
8 exactly more specifically what the needs are
9 in your ask for this particular year, but
10 obviously we have to deal with the lion in
11 the room first. You would agree with that.
12 And so my question to you is in order
13 to make sure that you get the revenues that
14 you rightfully desire, I mean, understanding
15 that it's going to be a bucket and it's
16 obviously full, but are you open to possibly,
17 if necessary, in order to make sure that
18 services are provided to all of the counties
19 in New York State, the possibility of raising
20 revenue? Have you thought about that, or you
21 haven't really thought about that in the
22 process of putting this comprehensive package
23 together?
24 MS. RAVENHALL: You know, I think

1 economic stability and raising revenue is
2 always something that's beneficial to the
3 state and something that we'd like to see.
4 In terms of funding local health
5 departments, one of the most important things
6 is anytime there's a new expanded mandate
7 that the state puts into law that's
8 protective and important, there has to be
9 some kind of flexible funding that covers,
10 you know, things like fringe so that we can
11 expand our workforce and hire new staff to
12 take on these mandates. So that's something
13 that I would want to reinforce.
14 But understandably, revenue and
15 economic stability is important for the
16 state.
17 DR. GUPTA: So some of those things,
18 as you have -- when I was speaking about, we
19 do the core public health function, which
20 nobody else will do that, to protect the
21 health of the community.
22 So usually in the healthcare sector
23 you can do fee-based. Here, there's no
24 fee-based, because our mission is to protect

1 everybody. So the revenue is not directly
2 attached in those services because these are
3 essential, to make sure everybody is treated
4 in the same way.
5 If that answers your questions. Like,
6 for example, in lead --
7 SENATOR JACKSON: Lead poisoning.
8 DR. GUPTA: Right. So in the lead, it
9 is very crucial that we are there to address
10 the need of the child, to reduce the
11 childhood exposure. That means we have to
12 not only monitor the lead levels when they
13 come to our doors, as -- in the local health
14 department, but to make sure that we put our
15 workforce to make sure they do house
16 inspections, they do case management.
17 And these are not typically
18 revenue-generated, because they are not part
19 of the healthcare system. So I as a
20 commissioner, I came from the healthcare
21 system where, if I did that service, then I
22 can charge and bill. Here, this is part of
23 the public good which a community does.
24 SENATOR JACKSON: Thank you. I saw

1 that in your presentation, and that's very
2 good. But obviously we have to deal with
3 this bigger picture, including everything
4 else.
5 DR. GUPTA: Right.
6 SENATOR JACKSON: Thank you very much.
7 DR. GUPTA: Thank you.
8 CHAIRWOMAN KRUEGER: Thank you.
9 Thank you very much. Appreciate your
10 testimony tonight.
11 MS. RAVENHALL: Thank you for the
12 opportunity.
13 CHAIRWOMAN KRUEGER: Thank you.
14 Feeding New York, Dan Egan. Then up
15 on deck next, New York State Nurses
16 association, followed with Medical Society of
17 the State of New York.
18 (Discussion off the record.)
19 CHAIRWOMAN KRUEGER: Good evening.
20 MR. EGAN: Good evening. How are you?
21 Thank you all for the opportunity to speak
22 this evening -- I'm going to go with
23 evening -- and also for your long standing
24 support to food charities. My name is Dan

1 Egan. I'm the executive director of Feeding
2 New York State. We are the membership
3 organization of the nine Feeding America food
4 banks in New York State. Last year our food
5 banks provided over 184 million pounds of
6 food to New Yorkers in need, and that
7 included 60 million pounds of fresh produce.
8 We have a hunger problem in New York
9 State. Today, as we all sit here doing this
10 important work, there are food bank trucks on
11 the road delivering donated food to our
12 hungry neighbors. Just down the road from
13 here, people have been known to line up at
14 midnight for trucks that they know won't be
15 there till midday. They're not teenagers
16 lining up to see a concert or get the next
17 iPod, they're there committing that kind of
18 time because their families need the food.
19 In New York City people cheer when
20 they see the City Harvest truck coming. They
21 know the drivers, they know that truck is
22 going to be full of good healthy food, and
23 they're that happy to see them. Our state is
24 filled with people who have never tasted the

1 very food that's grown by New York State
2 farmers because they've never had the
3 opportunity to buy fresh produce.
4 This hunger exists in every county of
5 our state, from Chautauqua to Clinton to
6 Suffolk. About 11 percent of all New Yorkers
7 and 17 percent of children are hungry. Most
8 of these folks are in households with jobs,
9 but the jobs do not pay enough, and due to
10 federal SNAP policy decisions, the situation
11 is about to get worse. Our colleagues at
12 Hunger Solutions estimate that over 110,000
13 New Yorkers are about to be affected, and
14 48,000 will lose benefits in April. And to
15 make up the gap for the food they're not
16 going to have will take about 27 million
17 pounds of food.
18 The tragedy is that this problem of
19 hunger is completely avoidable. New York
20 State farmers grow about 18 billion pounds of
21 produce every year, of which 1.2 billion
22 never leaves the farm -- that's billion with
23 a "b." It never leaves the farm because they
24 couldn't find a market. So this perfectly

1 good food is wasted. We're growing more than
2 enough food to feed everyone in this state.
3 And this is where food banks come in.
4 Food banks are the bridge between hunger and
5 food waste. We obtain donations of good but
6 unsold food and distribute it to those in
7 need. We work with farmers, food processors
8 and other donors. We're doing a lot now --
9 as I said, millions of pounds a year -- but
10 with your help, we could do a lot more.
11 I have all the science and the
12 statistics in my written remarks, so I won't
13 repeat all that here. But I think you all
14 know the effect that hunger has on people.
15 And the truly important thing you need to
16 know is that this is not an unsolvable
17 problem. It's a big problem, but it's not
18 unsolvable. And you here today have the
19 power to make a big difference.
20 So we're asking you for three things.
21 First, the Department of Health has the
22 Hunger Prevention and Nutrition Assistance
23 Program, or HPNAP. The Governor's budget set
24 that at just over $34.5 million, which is

1 about a half-million-dollar cut from last
2 year. And at minimum, we ask that you
3 restore that funding. The Legislature did
4 this last year, and we thank you for that
5 action. But it would be very disruptive to
6 the charities that depend on this flow of
7 money to have to make cuts in the middle of a
8 contract year.
9 Second, HPNAP has not been increased
10 for several years, yet the Governor has a
11 goal to reduce hunger by 10 percent by 2024.
12 With a $6 million increase in HPNAP, we can
13 get additional staff and cover other
14 operational expenses so that we can provide
15 far more service.
16 And third, we've worked closely over
17 the past year with the Department of
18 Agriculture and Markets on a plan to build a
19 statewide produce program that would link
20 New York State farmers to New Yorkers who are
21 hungry. This plan would link any farm in the
22 state to any food bank, and thus to any
23 community in need. It would provide milk and
24 a huge increase in fresh produce distribution

1 to our neighbors who are in need. We're
2 seeking $6 million for this new program, and
3 funding at this level could increase produce
4 distribution by tens of millions of pounds.
5 Together, these two initiatives could
6 completely close the new gap that we're about
7 to see being created by the federal SNAP
8 cuts.
9 So I thank you for the opportunity to
10 speak today. I'm running out of time. If
11 you have any questions, I'm happy to answer
12 them.
13 CHAIRWOMAN KRUEGER: Any Senators?
14 Senator Jackson.
15 SENATOR JACKSON: Hey, Dan. I just --
16 I didn't have a question, but I want to thank
17 you for coming in and giving us the details
18 of how much food is available to feed those
19 that really need. So I want to thank you on
20 behalf of all of those individuals that serve
21 the individuals that receive them, and I see
22 that all over New York City wherever I go.
23 Thank you.
24 MR. EGAN: Thank you, sir.

1 CHAIRWOMAN WEINSTEIN: Assemblyman
2 Cahill.
3 ASSEMBLYMAN CAHILL: Yes, thank you.
4 Hi, sir. Welcome. Just a quick
5 question to ask you if you're familiar with
6 the programs that are taking place in Ulster
7 County right now with regard to a combination
8 of assuring that otherwise wasted food would
9 get appropriately composted or a partnership
10 between restaurants, grocery stores and food
11 banks.
12 MR. EGAN: Yes, sir, that's actually
13 something that happens a lot all over the
14 state. Some people call it food rescue.
15 There's also a lot of gleaning projects down
16 that way. So yes, I'm familiar with both.
17 They're really commendable.
18 Both those sources of food put very
19 high-quality food, top-quality food into the
20 hands of people who need it, and they would
21 not otherwise have access. I was talking to
22 a food bank staffer just a few weeks ago who
23 was providing broccoli to --
24 ASSEMBLYMAN CAHILL: We won't hold

1 that against them.
2 MR. EGAN: -- food pantry clients --
3 broccoli? (Laughing.) She was talking to a
4 12-year-old girl, and she said, "Would you
5 like some broccoli?" And she was going to
6 show her simple ways that it could be
7 prepared. And the girl said, "Well, I don't
8 know, I've never eaten broccoli." She'd
9 never eaten broccoli because her family
10 couldn't afford it.
11 So it gets worse. Behind her was her
12 mom, who was maybe 30, 40 years old. And so
13 our staff person said to her, "Well, would
14 you like some broccoli?" And she said, "I've
15 never eaten fresh broccoli either."
16 So there are people in this state
17 reaching middle age who have not tasted the
18 food that's being grown down the road from
19 them.
20 ASSEMBLYMAN CAHILL: Do you have a --
21 and this is a very quick question, hopefully
22 a very quick answer. Do you have any
23 statistics on the actual cost of doing these
24 projects on a -- you know, relative to other

1 hunger initiatives?
2 MR. EGAN: Relative to?
3 ASSEMBLYMAN CAHILL: Like a food
4 program. Where we have to go out and buy the
5 food and prepare the food and --
6 MR. EGAN: Probably the closest I can
7 do is tell you that Feeding America, which is
8 the national food bank organization, they
9 estimate meal costs throughout the country.
10 And their estimate is that the average meal
11 cost in New York State is about $3.14. Now,
12 good luck getting a meal at that price in
13 New York City. But that's the statewide
14 average.
15 We can typically provide about four to
16 five meals for every dollar of funding that
17 we have. So it's far more effective, of
18 course, than, you know, participating in the
19 normal food market.
20 ASSEMBLYMAN CAHILL: Thanks so much.
21 CHAIRWOMAN KRUEGER: Thank you. No
22 questions. I just want to say thank you very
23 much for your work.
24 I started in food banking in 1981 at

1 the Cleveland, Ohio, Food Bank, started the
2 New York City Food Bank in 1983, have taken a
3 look at your proposal for the new sort of
4 farm-to-provider. It's exactly what we were
5 hearing forever. If we could just figure
6 out, you know, how you coordinated from the
7 farms to transportation to the emergency food
8 providers or food banks, it was a win/win.
9 So I'm looking forward to working with you on
10 that.
11 MR. EGAN: Thank you. Appreciate
12 that.
13 CHAIRWOMAN KRUEGER: Thank you.
14 Next up, New York State Nurses
15 Association, then Medical Society, and then
16 Physicians Assistants. A little theme of
17 providers of healthcare.
18 And around this time I'm supposed to
19 point out to people who feel like they have
20 to run to get a train to get back to New York
21 City, we still will take your testimony, it
22 still goes up online. But you're
23 comfortable, you've been here all day. You
24 all look very relaxed up there. So we're

1 just -- that's okay, you're allowed to sleep,
2 you're not on camera. We, on the other hand,
3 no sleeping up here.
4 Good evening.
5 MS. JORDAN: Good day. My name is
6 Cecilia Jordan. I'm the area director for
7 New York City Health+Hospitals and mayoral
8 agencies, and I'm here today on behalf of the
9 executive director of the New York State
10 Nurses Association -- NYSNA -- Pat King.
11 I want to thank the members of the
12 joint committee for the opportunity to
13 testify today. NYSNA represents over 42,000
14 registered nurses across New York State, and
15 our members strongly support universal
16 high-quality healthcare for all New Yorkers
17 regardless of ability to pay. Our members
18 share a commitment to provide care for our
19 communities that is consistent with
20 professional standards and nurse-to-patient
21 staffing ratios that allow us to do our jobs
22 under safe and fair working conditions.
23 We have provided the committee with a
24 full copy of our testimony, and our members

1 will be sharing our concerns in more detail
2 during the session. So I will focus my
3 testimony today on a few key areas of concern
4 in the proposed budget.
5 This year's Executive Budget is
6 primarily focused on addressing a projected
7 $4 billion overrun in the state's
8 self-imposed, quote, Medicaid global cap.
9 The state has already imposed midyear
10 actions, including a 1 percent
11 across-the-board cut in Medicaid
12 reimbursement rates that will save as much as
13 $851 million a year. In addition, the
14 Governor has convened a new Medicaid Redesign
15 Team, MRT, to find an additional $2.5 billion
16 in Medicaid spending cuts.
17 I want to say at the outset that we
18 are opposed to any changes in current
19 Medicaid programs that negatively affect the
20 available of services or the quality of care.
21 This is a priority for NYSNA.
22 Regarding the MRT, we have two main
23 concerns. First, that the MRT must include
24 strong representation of direct-care workers,

1 healthcare advocates, and end users or
2 consumers of Medicaid services, and they must
3 have an equal voice and vote. The MRT cannot
4 be perceived as packed in favor of providers.
5 Second, we are opposed to the mandate
6 that the MRT finds $2.5 billion in Medicaid
7 cuts. However, we are not opposed to efforts
8 to improve the efficiency of Medicaid-funded
9 health services, and we support efforts to
10 identify and root out fraud and waste.
11 We also have to remember, though, that
12 the 6.2 million New Yorkers receiving
13 Medicaid are dependent on these services and
14 that Medicaid monies are vital to our
15 safety-net hospitals and other providers.
16 That being said, NYSNA believes that
17 cutting Medicaid funding for the sake of
18 cutting is the wrong approach. First, we
19 believe that the $4 billion in cuts amounting
20 to more than 5 percent of current spending
21 will necessarily impact patients. You can't
22 take that much money out of the system
23 without causing some people to lose access to
24 services or affecting the quality of care.

1 Second, we believe that cutting
2 Medicaid is financially short-sighted and
3 counterproductive. The Governor and the
4 Legislature rightly called out the 2017 Trump
5 tax cuts for corporations and the ultra-rich
6 as a massive giveaway that was paid for by
7 working people in New York. New Yorkers pay
8 $22 billion more in federal taxes than we
9 receive back from the federal government.
10 The cap on state and local tax deductibility
11 may add another 15 billion a year to that
12 imbalance.
13 Given this inequity, we believe it is
14 foolish to reduce state spending on needed
15 Medicaid services when every dollar we cut
16 costs us $1 to $1.50 in lost federal matching
17 money. If we cut Medicaid by $4 billion, we
18 save $2 billion or less, but the Trump
19 administration gets to keep the rest, and our
20 patients pay the price.
21 Third, we believe that we should be
22 seriously considering revenue enhancements to
23 close the Medicaid gap and maximize federal
24 matching money. Areas to consider include

1 increasing corporate tax rates; target fees
2 or taxes at corporate and business entities
3 that will earn windfall profits in
4 healthcare -- after all, under the new
5 federal tax law, businesses are allowed to
6 fully deduct their state taxes; fully or
7 partially reinstitute the stock transfer tax,
8 which on its own could fund the entire gap.
9 Any discussion about restructuring
10 Medicaid must go beyond cost-cutting targets
11 and seriously address the way in which
12 existing spending is distributed.
13 The 1 percent across-the-board cut in
14 reimbursement rates, for example, was a
15 mistake because it did not distinguish
16 between profitable hospital networks.
17 We are also concerned about staffing
18 ratios -- sorry. Finally, before concluding,
19 we would also encourage the Legislature to
20 seriously consider the inclusion of
21 nurse-to-patient ratios in the final budget,
22 particularly if there are to be cuts in
23 Medicaid funding. Staffing ratios protect
24 the quality of care and help to ensure that

1 wasteful, unnecessary or preventable services
2 are reduced, as there are fewer admissions,
3 readmissions, financial penalties, nurse and
4 other worker turnover costs.
5 We are also concerned about the
6 provision to change professional practice
7 standards in the budget that could impact
8 patient care and safety. The budget proposes
9 to greatly expand the list of vaccines and
10 services that may be administered by
11 pharmacies. This is a complex issue that
12 needs greater thought and study. We believe
13 these types of practices should not be
14 addressed as part of the budget process.
15 Once again, I thank you for the
16 opportunity to speak today. I look forward
17 to meeting with you to discuss our concerns.
18 CHAIRWOMAN KRUEGER: Thank you. That
19 was the fastest. Thank you.
20 Senators? Senator Rivera.
21 SENATOR RIVERA: Thank you, Madam
22 Chair. And thank you both for being here.
23 MS. JORDAN: Thank you.
24 SENATOR RIVERA: So I will ask again,

1 as I am asking everyone else, were you --
2 have you been contacted by the administration
3 for -- to participate in the MRT process?
4 MS. JORDAN: No, we were not, Senator.
5 SENATOR RIVERA: You have not been
6 contacted by them.
7 MS. JORDAN: No, we were not.
8 SENATOR RIVERA: But obviously, as I
9 can see from your testimony, obviously you
10 believe that not only is it an important
11 process, but that representation of
12 front-line workers and actually people who
13 provide services would be quite important in
14 that conversation.
15 MS. JORDAN: Absolutely.
16 SENATOR RIVERA: Does the Nurses
17 Association have a position on the Medicaid
18 cap?
19 MS. JORDAN: Well, at my level of the
20 organization, I have not had those
21 discussions. But I think that we would be
22 interested in exploring that further, as the
23 majority of our members do serve patients
24 that are already living in and serving in

1 disproportionately affected communities, so
2 that would be something that would adversely
3 affect our patients and the communities that
4 our workers work in.
5 SENATOR RIVERA: Thank you for the
6 work that you do every day to make sure that
7 we're healthy, and thank you for being here
8 today.
9 MS. JORDAN: Thank you, Senator.
10 SENATOR RIVERA: Thank you,
11 Madam Chair.
12 CHAIRWOMAN KRUEGER: Robert Jackson.
13 SENATOR JACKSON: First let me thank
14 NYSNA for coming in. And when you started to
15 read, I didn't think that you were going to
16 finish everything that you had to say within
17 five minutes, but you sped up real quick.
18 Which is a good thing, because you finished
19 basically right on time.
20 And I was looking, even before it was
21 one minute into your speech, as soon as I got
22 looking here, and it says increase corporate
23 tax rates, increase the millionaire's
24 surcharge, target taxes and fees at corporate

1 and business entities that will make windfall
2 profits in healthcare. Reinstitute the stock
3 transfer tax.
4 Well, you sound like you want to make
5 sure that your nurses continue to work to
6 provide the services that they rightfully
7 give the people of New York State. And so
8 I'm glad that you came forward in saying that
9 yes, we look forward to the, what is it, the
10 Medicaid Redesign Team No. 2. But you don't
11 depend on that to get the job done.
12 MS. JORDAN: No, sir.
13 SENATOR JACKSON: And so that's a good
14 thing. And I'm glad that you are saying some
15 of the things that I'm saying, and some of us
16 are saying, that we have to raise revenue.
17 You just can't cut, cut, cut, cut, cut. And
18 I agree that you can make some changes and
19 you can deal with a lot of the fraud that's
20 in the system. I mean, obviously, no one
21 wants fraud to happen, you know what I mean?
22 But I thank you for your testimony.
23 And I hope that groups like 1199, NYSNA, and
24 other activists and others will be part of

1 the redesign team so that, you know, it's not
2 just one-sided, which is very, very important
3 in this particular matter.
4 But obviously -- I got this and I'm
5 going to read the details, and obviously in
6 the last paragraph you said "As more concrete
7 information emerges and we continue our
8 review of these and other Executive Budget
9 proposals related to healthcare, including
10 the proposed HCRA revisions, we will provide
11 more detailed analysis and position
12 statement." Well, we look forward to more
13 detailed statements.
14 MS. JORDAN: Thank you, sir.
15 SENATOR JACKSON: Thank you, Madam
16 Chairs.
17 CHAIRWOMAN KRUEGER: Thank you. Thank
18 you both for coming. We appreciate it.
19 MS. JORDAN: Thank you.
20 CHAIRWOMAN KRUEGER: Next up we have
21 the Medical Society of the State of New York,
22 I believe Morris Auster. And then for people
23 getting ready, Physicians Assistants
24 afterwards, and then Empire Center.

1 MR. AUSTER: Thank you very much,
2 Senator Krueger. And thank you for the
3 opportunity to present our perspectives on
4 the State Budget.
5 MSSNYS represents physicians of every
6 specialty, every region of the state, and
7 every type of practice construct -- small
8 group, large group, hospital employee --
9 delivering care to patients every day across
10 the State of New York.
11 Our written testimony touches on a
12 number of different aspects of the Governor's
13 budget, but I really just want to limit my
14 comments to a few different areas. I always
15 like to start with some nice things, and I
16 have to say there are some positive aspects
17 of this budget. Certainly, one, to be able
18 to limit the sale of flavored tobacco
19 products and to help prevent the health risks
20 associated with the vaping. Of course, also
21 want to thank Senator Hoylman and
22 Assemblymembers Bichotte and Rosenthal for
23 also advancing legislation in that area.
24 Legislation to require the

1 registration and oversight of PBMs. And
2 again, on the same level, Assemblyman
3 Gottfried, Senator Breslin, Assemblyman
4 Cahill, Senator Rivera have also been
5 sponsoring that. Hopefully we can actually
6 get a bill done this year in that area. And
7 then also, given the pervasive complaints
8 that physicians receive -- that we receive
9 every day from physicians across the state
10 about hassles they have with insurance
11 companies, efforts to achieve some form of
12 administrative simplification, including an
13 administrative simplification task force, and
14 a claims denial transparency report.
15 We also appreciate that the budget
16 includes funding for the Excess Medical
17 Malpractice Insurance program, but it has
18 been reduced. And I think there should be
19 some checking with the insurance industry
20 whether that will be actuarially sufficient.
21 Where we are very concerned -- and I
22 think we've had some of the discussion
23 earlier today, and I thank Assemblyman Cahill
24 for raising it -- is that the budget has not

1 extended the historical language associated
2 with the Excess Medical Malpractice Insurance
3 Program.
4 You may be aware that New York has
5 liability costs that far exceed any other
6 state in the country, even similar-sized or
7 bigger states like California, Texas and
8 Florida.
9 Well, unless the state is looking to
10 enact comprehensive liability reform to bring
11 down these costs, and we always know that's
12 been a very difficult issue, this Excess
13 Program is absolutely essential for
14 physicians and for patients, frankly, at the
15 end of the day as well. With the exorbitant
16 premium costs and runaway verdict sizes we
17 have in our state, physicians cannot practice
18 in our practice without -- with a fear that
19 every time they treat a patient, their home
20 or assets could be at stake.
21 We appreciate the Legislature has long
22 recognized this critical balance that this
23 program has provided, and look forward to
24 that program being fully funded and extended

1 as it typically has been.
2 We're also concerned with the threat
3 of further significant cuts to Medicaid
4 payments. The New York Medicaid payment is
5 already among the lowest in the country, and
6 it was just made worse by that 1 percent cut.
7 The direct physician payment is already a
8 very, very small part of New York's overall
9 Medicaid budget. With New York already
10 having the dubious distinction of being the
11 worst state in the country in which to be a
12 physician, and with many physicians already
13 being put in a position where they've been
14 forced to become hospital employees based
15 upon their own inability to keep a practice
16 open, any type of cuts, let alone the
17 potential cuts that could come along with a
18 $2.5 billion savings target would be -- would
19 just exacerbate this trend. In fact, for
20 many physicians it could be the death knell
21 for these community-based physician
22 practices.
23 Last but certainly not least, we are
24 extremely concerned with the scope of the

1 physician disciplinary proposal in the
2 Article VII bill. Simply stated, these
3 provisions have the potential to unfairly
4 destroy a physician's career. New York's
5 physician disciplinary process already
6 provides ways by which the Commissioner of
7 Health can bypass the required due process
8 protections when there are exigent
9 circumstances.
10 The overwhelming number of complaints
11 that are filed against physicians result in
12 no actual action being taken, yet any
13 complaint -- based upon the language, any
14 complaint, no matter how minor, could
15 theoretically become public or result in an
16 immediate summary suspension of the physician
17 at the whim of the commissioner, without any
18 fair due process first.
19 With Google, Yahoo and other search
20 functions, a public report that a physician
21 is under investigation or has been summarily
22 suspended, even if subsequently overturned,
23 would make it nearly possible for that
24 physician to get their reputation back.

1 We're always anxious to find ways to
2 address gaps in our disciplinary system to
3 protect the public, as we did a couple of
4 years ago with the provisions relating to
5 when a physician has been accused of a felony
6 not related to healthcare. But this proposal
7 that's been put forth goes way too far. We
8 urge that it be taken out of the budget.
9 We have many other items in our
10 written testimony that identify, but for the
11 sake of time, you can read them at your
12 convenience. And we thank you for the
13 opportunity. I'm happy to answer any
14 questions.
15 CHAIRWOMAN KRUEGER: Senators?
16 Senator Rivera.
17 SENATOR RIVERA: Yes.
18 Hello, Moe, how you doing?
19 MR. AUSTER: How are you?
20 SENATOR RIVERA: Thank you for hanging
21 out.
22 So has the Medical Society been
23 approached by the administration for its
24 potential participation within the MRT

1 process?

2 MR. AUSTER: We have not. To be fair,

3 we have asked that if one gets put together,

4 we would like to make sure there is a

5 representative of organized medicine. But we

6 have not been directly asked to be a

7 participant.

8 SENATOR RIVERA: And to be fair,

9 everyone except the administration has kind

10 of said the same thing.

11 But -- okay, so is there a position

12 that the Medical Society has on the Medicaid

13 cap?

14 MR. AUSTER: We do not have a formal

15 position on it.

16 I will say we do not -- physicians do

17 not get cost trend increases each year. The

18 fee schedules are where they are. There have

19 been isolated increases over the years. So I

20 guess, theoretically, if you were to raise

21 the cap, that could make it likely to have

22 some kind of further increase in the future.

23 Like I said before, our rates are far

24 lower compared to many, many other states.

1 Others base it based upon a percentage of
2 Medicare -- near Medicare. Ours is like
3 50 percent of Medicare. So theoretically, if
4 you raise the cap, that could make it more
5 likely, but we do not have an official
6 position on it.
7 SENATOR RIVERA: Okay. Thank you,
8 sir. Thank you, Madam Chair.
9 CHAIRWOMAN WEINSTEIN: Assemblyman
10 Byrne.
11 ASSEMBLYMAN BYRNE: Yes, thank you for
12 being here.
13 And I was hoping that you could just
14 elaborate a little bit more on that section
15 of the Executive Budget, I think it's Part L,
16 with the section regarding the Office of
17 Professional Misconduct, and just the
18 concerns I think that are raised that if
19 someone makes an accusation, this could
20 not -- it could completely, in my mind,
21 damage someone's entire career. Because like
22 you said, with Google and Yahoo, how is
23 someone supposed to go back to their life and
24 to work with some accusations out there?

1 I mean, I have some concerns about due
2 process in general on that. We've taken
3 steps outside of the healthcare side, and out
4 of this committee, just to protect everyday
5 citizens from trying to be grouped into --
6 you know, being put on the internet without
7 their due process.
8 If you could elaborate a little bit on
9 that. And I also wanted to ask you just one
10 other question. I see in your testimony the
11 opposition from MSSNY for recreational
12 marijuana. And I do have some concerns that
13 while the Governor has put forth some
14 proposals for stricter tobacco controls or
15 even the marketing practices, at the same
16 time we're talking about potentially
17 legalizing marijuana for recreational use.
18 And some of you have already said, in
19 the previous testimony, that could be a
20 potential revenue raiser to offset the
21 Medicaid gap. I have some concerns about
22 that but would like to just hear your
23 thoughts and see if you can elaborate on it.
24 MR. AUSTER: Yes. Well, on the

1 disciplinary front, we have long maintained
2 that we needed to have a balanced system
3 within the disciplinary process. We have
4 recognized over the years that there are
5 times -- there's a process, there's an
6 investigation, there's an investigation
7 committee, there's a hearing committee. We
8 have recognized over the years in creating
9 the process that there are times based upon
10 certain circumstances when you do need to
11 jump the line and take expeditious action
12 based upon a certain circumstance.
13 You have that standard now, with the
14 imminent danger standard that's been put
15 forward in the law that we believe addresses
16 the circumstances. You also have the
17 circumstance now where once -- right now --
18 last year I believe there were 9,000
19 complaints that were filed with the OPMC, of
20 which 250, I think, ultimately were referred
21 for charges -- not even final disposition,
22 but just had charges brought against them.
23 Once you reach the stage of actual
24 formal charges, that information can be made

1 public. The concern we have is when before
2 the time that it actually becomes -- before
3 the time you actually realize there is a
4 potentially very serious situation going on,
5 that information can be made public. And
6 once that information is made public, there's
7 no chance a physician can ever get their
8 reputation back.
9 We feel that there's an adequate
10 balance right now. But like I said, we are
11 always anxious to find ways -- if there are
12 gaps in the process, we are anxious to find
13 ways in which we can, you know, work
14 towards -- to address those gaps. But this
15 goes off in a completely different direction.
16 And frankly, I'm not even sure what it's even
17 doing in the budget in the first place.
18 And then on your question on
19 marijuana, we continue -- the Medical
20 Society, like many other organizations, I
21 think like the PTAs, like the county health
22 officials, we continue to have strong
23 concerns with the legalization of
24 recreational marijuana. There's been

1 information that the CDC just put out that
2 even with legal sources, that that's been a
3 significant cause of instance where you've
4 had vape-borne injury in other states. And
5 we certainly understand the need to try and,
6 you know, address certain societal wrongs.
7 We think the Legislature did an important
8 step last year through the enhancement of
9 decriminalization last year. But based upon
10 some public health risks that we've seen in
11 others states, we still continue to have
12 significant concerns.
13 ASSEMBLYMAN BYRNE: Thank you.
14 CHAIRWOMAN KRUEGER: Thank you.
15 CHAIRWOMAN WEINSTEIN: Thank you, Moe.
16 CHAIRWOMAN KRUEGER: Thank you very
17 much for being here tonight. Next up is the
18 New York State Society of Physician
19 Assistants.
20 MS. REGAN: Good evening.
21 CHAIRWOMAN KRUEGER: Good evening.
22 MS. REGAN: It definitively is
23 evening. And I thank you for the opportunity
24 to be here to give this testimony on how PAs

1 can be the solution to help New York State's
2 quadruple aim, to increase access to
3 high-quality, cost-effective care and
4 enhancing provider satisfaction.
5 PAs represent a transformational
6 opportunity to positively impact the state's
7 bottom line while improving patient access to
8 care in primary and specialty care settings,
9 including health promotion and disease
10 prevention. Timely, quality access to care
11 reduces a patient's need to seek costlier
12 visits to urgent care for non-urgent visits
13 and allows for making a timely diagnosis of
14 disease states, conditions more costly to
15 treat at an advanced stage.
16 In an inpatient setting, a PA's
17 ability to see Medicaid managed care patients
18 facilitates throughput, decreases length of
19 stay, thereby reducing significant cost and
20 creating bed capacity. PAs in specialty care
21 can increase access for Medicaid patients who
22 wait sometimes months to be seen by a
23 specialist.
24 PAs are trained in medicine, and we

1 practice very autonomously with our physician
2 colleagues and other members of the
3 healthcare team. This effort extends from
4 the state's pre-hospital-care footprint
5 through end of life and palliative care
6 decision-making. This was supported on a
7 bill passed in 2010 and further clarified in
8 a memo issued by Assemblyman Gottfried in
9 2019. PAs have unrestricted licenses, like
10 our physician colleagues. That is, we can
11 see patients of every age and patient acuity
12 in every healthcare setting.
13 As medical staff, PA quality assurance
14 is overseen via the same infrastructure as
15 our physician colleagues. Hospitals,
16 outpatient facilities, long-term and
17 short-term care, patient-centered medical
18 homes are all entities that PAs see patients
19 in. This makes PAs a very versatile
20 healthcare workforce solution, incorporating
21 genetic and social determinants of health.
22 Despite this, payers, including
23 New York State Medicaid managed care
24 entities, do not credential PAs nor allow

1 them to have patient panels. This restricts
2 patients from identifying PCPs in their
3 community. It also forces them to rely on
4 urgent cares if there are not enough PCPs
5 available to them. As we know, urgent cares
6 are an invaluable resource, but they are not
7 primary care entities and are more costly.
8 Additionally, if a PA is not
9 credentialed by a New York State managed care
10 plan, a patient pays a significantly greater
11 copay to see a PA, as a visit is deemed an
12 out-of-network visit by the payer.
13 I received a phone call from a PA who
14 practices in Westchester. He's a primary
15 care PA. And when Medicaid managed care
16 patients come in to see him, they are
17 required to pay a $75 copay. They walk into
18 that same visit to see the primary care
19 physician that he collaborates with, and that
20 patient's copay is $25.
21 The important issue is of concern
22 across the state. It has been explained to
23 NYSSPA that leaders in One Brooklyn Health
24 are looking towards PAs as an integral part

1 of their quality, cost-effective workforce
2 solution and are frustrated about the
3 inability to enroll PAs with New York State
4 managed care. There are PAs across this
5 state who see patients in communities, rural
6 and urban, who cannot recruit physicians; PAs
7 are often the only medical providers
8 available to them.
9 PAs are an integral component to
10 New York State Medicaid shared saving plans
11 and are capable of leading care teams. There
12 are many municipal workers across the state
13 whose insurance does not credential PAs.
14 This creates the same costly lack of access
15 to care as the New York State Medicaid
16 managed care paradigm does. For our
17 downstate legislators, Emblem Health, which
18 covers FDNY, NYPD and other municipal
19 workers, is one.
20 This is an administrative fix that
21 needs timely conversation to ensure policy
22 and contract language to include PAs.
23 There is a physician shortage, and
24 many physicians in practice are experiencing

1 burnout. One of the main causes of burnout
2 is the sheer volume of patients. PAs are the
3 solution. By having all New York State
4 Medicaid and third-party payers credential
5 PAs and allow them their own patient panels,
6 access to primary care and specialty services
7 will be increased.
8 There are over 14,000 licensed PAs in
9 New York State, and State Ed is adding a
10 thousand licenses a year. I have sat through
11 many hours of testimony today about solutions
12 to New York State's healthcare problem. Not
13 once has the PA profession been named as a
14 solution, a profession that is capable and
15 competent. There are 23 accredited PA
16 programs in New York State, with five in the
17 pipeline.
18 We are a young workforce. I will put
19 on public record I am at the pinnacle of the
20 aging population. The majority of the PA
21 workforce is female and less than 45 years of
22 age.
23 As a stakeholder in this, NYSSPA looks
24 forward to working with the New York State

1 Legislature and the Medicaid Redesign Team to
2 meet the challenge and be part of the
3 solution. We were not part of MRT I. We
4 have not been asked to be part of MRT II --
5 sorry, Gustavo, I'll take your thunder
6 earlier -- and we look forward to partnering
7 autonomously with our physician colleagues
8 and our Legislature to take care of the
9 patients of New York State.
10 CHAIRWOMAN KRUEGER: Thank you.
11 Any questions? She got the answer
12 already. Anyone else?
13 CHAIRWOMAN WEINSTEIN: Assemblyman
14 Byrne.
15 ASSEMBLYMAN BYRNE: First, I know
16 we're trying to limit our comments, but I
17 want to thank you for being here, Maureen.
18 And I do think that physician assistants are
19 definitely one of the tools, part of the
20 answer to our healthcare system increasing
21 access to care. And I just want to thank you
22 for being here.
23 And my wife is one of those
24 statistics, and I hope I won't get in trouble

1 for saying 35, so she's under that number,
2 and she's actually working right now. And
3 she'll tell me that -- always reminds me that
4 it's -- I'm happy that that was correct, when
5 you were on the TV there, because it's
6 physician assistant, not physicians
7 assistants.
8 MS. REGAN: Thank you. I had that
9 corrected.
10 ASSEMBLYMAN BYRNE: Good job. Thank
11 you again.
12 CHAIRWOMAN KRUEGER: Anyone else?
13 Then thank you very much for being here.
14 MS. REGAN: Appreciate it. Thank you.
15 CHAIRWOMAN KRUEGER: Great. Next up
16 is Bill Hammond, from the Empire Center.
17 MR. HAMMOND: Good evening.
18 CHAIRWOMAN KRUEGER: Good evening.
19 MR. HAMMOND: Thank you all for having
20 me to testify, and thank you for sitting
21 through all of this.
22 As I say in my written testimony, the
23 main problem with the Governor's budget is
24 that it barely exists. It's really -- the

1 normal process is for him to lay out a series
2 of detailed spending proposals, normally he's
3 looking to control Medicaid spending in some
4 way. But this time, instead, he delegated it
5 to the Medicaid Redesign Team. The Medicaid
6 Redesign Team doesn't exist yet, as has been
7 discussed. The timing is very bad.
8 It's possible -- since we don't know
9 the membership, it's kind of hard to know,
10 but it's possible the MRT will come up with a
11 great plan. It's just that it should have --
12 if you were going to do it that way, it would
13 have been better to have started several
14 months ago.
15 The result is that we have a big blank
16 spot where the Medicaid budget should be, and
17 that is kind of a continuation of a long-term
18 problem of delaying action that is necessary,
19 and withholding information. And those --
20 that pattern is what brought us to this point
21 today. That's like the proximate cause of
22 our deficit.
23 He does have one -- the Executive
24 proposal does include one concrete concept,

1 that's the new deal with the county share of
2 Medicaid. I have to say that that's about
3 shifting costs, it's not about controlling
4 them, and it's shifting them in the wrong
5 direction, I would say.
6 It's also discouraging that there's
7 been already a discussion of what the
8 Governor referred to as "additional industry
9 revenue." That sounds an awful lot like
10 taxes on health insurance. We already rely
11 very heavily on health insurance taxes. This
12 makes our coverage less affordable for people
13 who buy it, for the employers and the
14 consumers who buy it. If those rates go up
15 too high, people are going to lose coverage,
16 and that's going to put more pressure on the
17 Medicaid budget.
18 I think it's important to emphasize --
19 there's been a lot of talk about the
20 2.5 billion. And that is -- that's a large
21 number. It's roughly 10 percent of the
22 projected spending in 2021. But to put this
23 in perspective, if you look in the financial
24 plan, the total Medicaid spending for the

1 year we're in now is projected at
2 $26 billion, and the amount of the Governor's
3 budget for 2022 is also $26 billion. There's
4 a small decrease, but it's essentially flat.
5 And if you look back at what you approved
6 last March, that was $24 billion.
7 So if you do the full 2.5 billion in
8 cost savings that the Executive is proposing,
9 you end up with a budget that's $2 billion
10 higher, 8 percent higher than what you
11 proposed last year. And it's double digits
12 higher than what you proposed two or three
13 years ago.
14 That is the rate of growth that we're
15 seeing in Medicaid. It's growing so fast you
16 have to take a pretty big crack at it just to
17 keep it flat.
18 And when I hear providers say that if
19 you do this, if you take that 2.5 billion,
20 you're going to -- that people are going to
21 close and people are going to lose their
22 services, the subtext there is if we don't
23 get a 10 percent increase, we're going to go
24 out of business. And I don't think that's

1 sustainable.
2 I guess another point I would make is
3 we're not talking about -- we shouldn't be
4 talking about across-the-board cuts where
5 everybody has to take a 10 percent hit or
6 anything like that. You should be targeting
7 the reforms, the cost savings, the
8 efficiencies to the areas where it's most
9 necessary.
10 I will say that I think you should
11 reject the HCRA taxes, the Health Care Reform
12 Act taxes. You should preserve the freeze,
13 if not lowering the local share. And then
14 you need to look for -- you need to focus on
15 the areas where spending has grown most
16 quickly.
17 There's been a lot of talk about
18 long-term care, and I will agree some of that
19 is the result of demographics. I looked up a
20 couple of numbers. In the two-year period
21 from 2016 to 2018, the over-75 population
22 grew by 4 percent. And that, in the context
23 of New York State, where our population is
24 actually shrinking -- 4 percent growth.

1 That's a lot by the standards of New York
2 State.
3 In that same two-year period, though,
4 managed long term care enrollment was up
5 31 percent in two years. So yeah, there's
6 some demographics going on, but that's not
7 the primary thing.
8 So I've run out of time, but I'm happy
9 to -- if you have any questions, I'm happy to
10 answer them.
11 And in anticipation --
12 SENATOR RIVERA: No, no, no, sorry,
13 sorry, sorry. I need to ask the question.
14 (Laughter.)
15 CHAIRWOMAN KRUEGER: Senator Rivera
16 next.
17 SENATOR RIVERA: Mr. Hammond,
18 officially and for the record, sir -- you are
19 being recorded, sir --
20 MR. HAMMOND: Yes.
21 SENATOR RIVERA: For the record, have
22 you been contacted by the Cuomo
23 administration for your potential
24 participation in the MRT? Be honest, sir.

1 MR. HAMMOND: I have not. I think
2 Eric Linzer nominated me --
3 (Laughter.)
4 MR. HAMMOND: -- but I have not been
5 contacted by the Governor's office.
6 SENATOR RIVERA: I'll just say, also
7 for the record, we disagree a lot, but I'm
8 very, very thankful at the way that you
9 approach this, the -- it is -- I have learned
10 a lot from actually reading some of your -- a
11 lot of the analysis that you do, and I
12 appreciate the fact that there's somebody
13 coming from a different perspective and still
14 come to trying to solve the problem. I
15 appreciate that. And I would hope -- I mean,
16 because I don't know who's in the MRT. I
17 mean, I guess somebody's on it. I mean,
18 if -- it would be -- let's just dream of a
19 situation in which all the different folks
20 that we talked about are there, and we're
21 both there too. One can dream.
22 MR. HAMMOND: Thank you. Thank you
23 for saying that, Senator.
24 SENATOR RIVERA: Thank you for hanging

1 out, by the way.
2 CHAIRWOMAN KRUEGER: Assembly?
3 All right, well then I also want to
4 just thank you for your work. I feel like
5 Gustavo. We disagree on the analysis, but I
6 appreciate that you do it.
7 So again, we know why Medicaid is
8 growing. Right? We are getting older, and
9 older people spend more money on healthcare.
10 We're getting poorer as we get older, so
11 they're on Medicaid. We have this system
12 that the Governor proudly said 95 percent of
13 New Yorkers are insured. But they're insured
14 because when the ACA went into effect and we
15 created the New York State of Health and
16 everybody was told, Go find out which
17 insurance is cheapest and best for you --
18 because otherwise you're going to get a
19 penalty if you don't sign up -- 40 percent of
20 the people who showed up were eligible for
21 Medicaid.
22 So, you know, the only place I think I
23 disagree with you is it's not like a surprise
24 that costs are going up in Medicaid, it's

1 because the population went from 4.7 to
2 6.2 million people who were eligible and
3 participating. Do you disagree those people
4 aren't eligible for Medicaid?
5 MR. HAMMOND: Well, okay, there's two
6 points to be made here. First of all, the
7 enrollment has been -- overall enrollment has
8 been flat for about four years. And so I
9 would have expected that spending would have
10 stabilized by now. You might have seen
11 like -- you know, when people are first
12 enrolling, you would expect a surge in
13 expenses. But the enrollment is not surging
14 anymore, it hasn't been surging for a number
15 of years.
16 With respect to do -- are the people
17 on there eligible, I assume that most of them
18 are.
19 I would say there's been any number of
20 audits, both by the federal government and
21 the State Comptroller, and every time they
22 audit it, they find pretty substantial
23 percentages of people where, when they look
24 at the records and they line them up against

1 the eligibility guidelines, they don't appear
2 to be eligible. And when I say substantial
3 numbers, there's one federal audit that found
4 15 percent were either -- did not match the
5 eligibility or there weren't enough records
6 to verify that they matched the eligibility.
7 So I think there is probably some
8 number of people on the rolls who arguably
9 don't belong there. And if you were looking
10 for strategies to save money, checking for
11 that kind of thing, checking to make sure
12 that they aren't dead, checking to make sure
13 that they aren't already enrolled in some
14 other insurance and we're still paying
15 premiums for them, that's, you know,
16 healthcare management 101.
17 CHAIRWOMAN KRUEGER: Thank you very
18 much for being here tonight.
19 CHAIRWOMAN WEINSTEIN: Excuse me. We
20 have a question from Assemblyman Byrne.
21 ASSEMBLYMAN BYRNE: Sorry. I wasn't
22 going to ask a question, because I know it's
23 getting late, but I figured you're here and I
24 saw you up in the audience, Bill, here the

1 entire time.
2 So I am kind of curious if you had any
3 thoughts based on the testimony of the
4 commissioner and Medicaid director, the
5 Department of Health commissioner, when we
6 were talking about specifically when this
7 budget deficit started to build last year and
8 the fact that they shifted the 1.7 billion
9 from one fiscal year to the next. It seems
10 to me that that wouldn't be best practice for
11 most people in accounting. But also it just
12 seems that there was an opportunity to maybe
13 get ahead of this months ago and start this
14 process maybe earlier, and now we're kind of
15 under the gun.
16 But I was curious what your thoughts
17 were on that. I don't even know where the
18 authority comes to shift the payments from
19 one fiscal year to the next, because I get
20 the thought that we vote on the budget for
21 one fiscal year. But if you could just
22 elaborate and give us your kind of response
23 on what you heard today.
24 MR. HAMMOND: So I think the

1 overspending issue actually goes back maybe
2 three or four years. It started relatively
3 small. There was a disclosure in the middle
4 of 2019 where they said we've been managing
5 the timing of Medicaid payments going back to
6 2015. And it started in -- you know, I think
7 it was 50 million, and it built. And I think
8 I believe it got larger from year to year.
9 And so 1.7 billion could be seen as kind of
10 an accumulated deficit that was rolled
11 forward.
12 I think that the time to disclose that
13 kind of a situation, especially when you're
14 getting into the third or fourth year of
15 rolling over unpaid bills, is at the
16 beginning of the budget process in January,
17 so a year ago now. That would have been a
18 good time to disclose it.
19 That way it would have been on the
20 table for the Legislature to be aware that
21 spending was higher than they thought it was.
22 And they could have prepared a new budget
23 that absorbed that increase one way or the
24 other, either by efficiency reforms, which

1 would have been my preferred approach, or, if
2 you're going to do revenue, the time to do
3 revenue is during the budget process.
4 So delaying the payment, especially
5 without public notice, guaranteed that the
6 new budget was going to be out of balance.
7 And not just by the amount of the delayed
8 payment, but also by the amount of the higher
9 spending level that you weren't aware of. So
10 that's -- that's why I say that's the
11 proximate cause of the deficit. It's not
12 just the spending, it's also the management
13 of that spending.
14 ASSEMBLYMAN BYRNE: Okay, thank you.
15 I appreciate your time.
16 CHAIRWOMAN WEINSTEIN: Thank you.
17 Next we have, from the Schuyler Center
18 for Analysis and Advocacy, Bridget Walsh,
19 senior policy analyst.
20 And just if you're keeping score, the
21 next is Medicaid Matters New York, then to be
22 followed by the Pharmacists' Society of the
23 State of New York.
24 Thank you.

1 MS. WALSH: Good afternoon. Thank you
2 for the opportunity to address you today with
3 our thoughts on the Executive Budget. My
4 name is Bridget Walsh, and I am a senior
5 policy analyst at the Schuyler Center.
6 The Schuyler Center is dedicated to
7 policy analysis and advocacy in support of
8 public systems that meet the needs of
9 disenfranchised populations and people living
10 in poverty. We often work in the areas that
11 fall between multiple systems, including
12 physical health and mental health, child
13 welfare, human services, and early childhood
14 development.
15 First, like many before me today, I'd
16 like to mention our concerns with the
17 Executive's plans for Medicaid. Medicaid is
18 critical for children and families. In fact,
19 48 percent of New York's children zero to 10
20 are covered by Medicaid, and 59 percent of
21 kids zero to 3 are covered by the Medicaid.
22 As we heard in many of the comments
23 today, the MRT II has a tight timeline to
24 generate proposals, and we believe it's

1 important for the Legislature to be engaged
2 in this work to ensure that any
3 recommendations live up to the Governor's
4 admonition that proposals not impact
5 beneficiaries or benefits.
6 We applaud the many calls we have
7 heard here today from our colleagues and
8 legislators that this new incarnation include
9 a breadth of perspectives. We believe that
10 this should include but not be limited to
11 people with disabilities, family members of
12 children covered by Medicaid, older adults,
13 people in historically underserved
14 communities, and people of color from the
15 beginning of the process.
16 We're also very heartened, as I sat in
17 the audience today, to hear many of your
18 concerns about the Medicaid cost shift to
19 localities. The executive proposal risks
20 augmenting inequalities among communities and
21 harming people in lower-income communities
22 that have higher Medicaid enrollment and
23 costs but less capacity to raise revenue.
24 Families in poverty receive assistance

1 from a range of services and programs funded
2 and operated at the local level. We fear
3 that diverting monies to pay Medicaid costs
4 poses risks to the ability of local entities
5 to fund these other services and may lead to
6 other cuts that harm children and families.
7 On the issue of Early Intervention,
8 the Schuyler Center is a member of the Kids
9 Can’t Wait campaign that brings together
10 individuals and organizations from throughout
11 New York with the goal of bringing the Early
12 Intervention and preschool special education
13 systems into compliance with federal law and
14 ensuring that young children receive the
15 services and therapy they need in a timely
16 manner.
17 We are also a member of the steering
18 committee of Winning Beginning New York,
19 which has carefully examined the EI landscape
20 in New York. As you will hear from others
21 today, New York's low payment rate for Early
22 Intervention has driven providers out of the
23 program, jeopardizing services for children
24 across the state. We believe that the rates

1 remain too low, and that a rate increase of
2 10 percent should be extended to all EI
3 providers, evaluators, and service
4 coordinators to begin to restore their rates
5 to where they need to be to ensure that
6 children with developmental delays or
7 disabilities get the timely access to
8 services they urgently need.
9 We think that the pay-and-pursue
10 proposal is a modest step towards improving
11 the imbalance between government payers and
12 insurance companies, but the budget misses an
13 opportunity by not dedicating services to
14 increasing reimbursement rates.
15 The Executive Budget also contains a
16 number of measures and resources to improve
17 maternal mental health from pregnancy to
18 childbirth and the early postpartum -- and
19 the postpartum period.
20 We applaud the Governor's work in this
21 area, and we hope that you support those
22 initiatives. We also expect to have some
23 policy recommendations around maternal mental
24 health in the future, and we look forward to

1 working with you on those proposals as well.
2 We also ask that additional
3 investments be made to support maternal
4 infant and early childhood programs around
5 New York State. You have information on that
6 in your packets.
7 And the other issue we want to finally
8 draw your attention to is a proposal in the
9 Executive Budget that substantially changes
10 the EQUAL program for adult homes. For many
11 years, the Schuyler Center has worked with a
12 coalition for adult home reform in advocating
13 for improved community and supportive housing
14 options for persons with psychiatric
15 disabilities living in adult homes, and for
16 improved conditions and a more robust
17 oversight of adult homes.
18 The EQUAL program is a lasting legacy
19 of years of hard work on the part of
20 advocates. While the budget proposal does
21 not cut the funding, the language proposes an
22 overhaul to the program that restricts how
23 the funding can be used. We are still
24 working with partners to fully assess the

1 implications of these changes, but we are
2 concerned that a change to the statutory
3 intent of the program will further
4 marginalize adult home residents. We ask you
5 to look very closely at those proposed
6 changes.
7 Thank you.
8 CHAIRWOMAN WEINSTEIN: You made it
9 just in time, and there aren't any questions.
10 Just so everybody knows, so all of the
11 people who had submitted testimony in advance
12 electronically, that had been shared by all
13 of the members of the Ways and Means
14 Committee and the Health and Insurance
15 Committees, so people will have your
16 testimony. Besides, it will be posted.
17 Thank you so much for being here.
18 Next we have Medicaid Matters
19 New York, Lara Kassel, coalition coordinator,
20 to be followed by the Pharmacists Society of
21 New York.
22 MS. KASSEL: Good evening. Thank you
23 very much for the opportunity to address you
24 this evening. Thanks also to your staff for

1 being here.
2 I am grateful to be testifying earlier
3 than I ever have before on behalf of Medicaid
4 consumers and Medicaid consumer advocates. I
5 would urge you in the future to figure out a
6 way to mix up the witness list so that other
7 advocates can also be testifying as early as
8 I am.
9 Medicaid Matters New York is the
10 statewide coalition representing the
11 interests of the people who are served by
12 New York's Medicaid program. You have my
13 written testimony; I'm only going to provide
14 a few points on it to you this evening.
15 Our membership is statewide. There
16 are over 100 coalition members, including
17 consumers, individual advocates, legal
18 services attorneys, representatives from
19 community-based organizations, and
20 community-based providers, and we work
21 together to advance the interests of Medicaid
22 beneficiaries.
23 As you'll see in my written testimony,
24 Medicaid Matters has some experience in MRT

1 proceedings. I bring perhaps some unique
2 perspective as the lone consumer advocate on
3 the original MRT. So many of the comments
4 that were made today by you and your
5 colleagues and others who testified today
6 really resonated with me -- and I'm sure with
7 many of my colleagues within our coalition --
8 regarding the makeup of the MRT, regarding
9 the importance of meaningful consumer and
10 community input and feedback and, as has also
11 been indicated by Senator Rivera and others,
12 a meaningful timeline.
13 So -- and to answer Senator Rivera's
14 question, no, I have not yet been invited. I
15 have not been invited to sit in on an MRT II.
16 Regarding the global cap, our
17 coalition members have been coming to our
18 coalition-wide monthly group calls -- you
19 know, we operate very much as a grassroots
20 coalition. We get on the phone once a month,
21 we have a listserv, and people post freely on
22 the listserv for open dialog among the
23 coalition members. Our coalition members
24 have been saying for a number of years now

1 that the Medicaid global cap really must be
2 re-examined, and in particular that there
3 needs to be transparency about what the
4 global cap is, how it operates, how it is
5 used as a tool, and how decisions are made
6 about what's in the cap, what's out of the
7 cap, as far as real policy decisions about
8 Medicaid finances and how things fit under
9 the cap or don't fit under the cap. And
10 those conversations within our coalition
11 continue even as of today with traffic on our
12 listserv.
13 I'd like to leave you, however, with
14 the most important message that I have to
15 deliver to you, and it hearkens back to the
16 mission of Medicaid Matters and my job as the
17 coalition coordinator. And that is to remind
18 you and the Governor and state agency
19 officials and really, frankly, all of us
20 about the intent of the Medicaid program, and
21 that is to provide coverage and access to
22 services for low-income people and people
23 with disabilities.
24 I'll share with you, because it's a

1 lovely visual -- we have a Medicaid stories
2 packet, we published this a couple of years
3 ago. Stories are always important, I think,
4 to drive home the importance of programs and
5 in particular Medicaid, and there are five
6 stories of real New Yorkers to highlight and
7 emphasize the importance of the program and
8 remind us all that Medicaid is intended to be
9 a coverage and access program for
10 New Yorkers.
11 And I'll, just in closing, leave you
12 with some comments that I got in response to
13 a statement that we put out on the Governor's
14 budget on Friday. We had many coalition
15 members email me to say: Thank you for
16 delivering the message, thank you for
17 highlighting the importance of consumer
18 advocacy and in particular representation on
19 the MRT, perhaps re-examining the global cap.
20 But the message that resonated most to
21 me and was most meaningful to me was one that
22 I got from a coalition member who is a young
23 woman, I think she's about my age, and she's
24 someone who benefits from the CDPA program

1 and the Nursing Home Transition and Diversion
2 Waiver. And she, in a very impassioned way,
3 thanked me for delivering the message that
4 Medicaid needs to stay strong for the people
5 who rely on it every day.
6 CHAIRWOMAN WEINSTEIN: Thank you for
7 being here. If you want to send an
8 electronic copy of that report that you held
9 up, we'll make sure that it's included with
10 your testimony and post it online.
11 MS. KASSEL: Thank you, I'd be happy
12 to. It's also on the Medicaid Matters
13 website.
14 CHAIRWOMAN WEINSTEIN: Sure.
15 SENATOR RIVERA: (Indistinct.)
16 CHAIRWOMAN WEINSTEIN: She already
17 answered your question. She answered your
18 question in -- okay -- but she answered your
19 question in your absence.
20 But -- Senator Rivera.
21 SENATOR RIVERA: Thank you.
22 Sorry about that. Took a quick bite,
23 and so --
24 MS. KASSEL: Got it.

1 SENATOR RIVERA: I missed that you did
2 answer the question, but I actually found a
3 follow-up, because I was told -- although you
4 have not been contacted to be part of the MRT
5 this time, apparently you were a member in
6 the original process.
7 MS. KASSEL: I was.
8 SENATOR RIVERA: And how were you
9 contacted originally to actually be a member
10 of the process?
11 MS. KASSEL: I received a call from
12 someone in the administration, I don't
13 remember who it was, and I was invited as the
14 lone consumer advocate after Medicaid Matters
15 put out a statement saying that it was
16 inappropriate and irresponsible for the
17 Medicaid Redesign Team to exclude consumer
18 representation.
19 SENATOR RIVERA: And this was -- the
20 timing of this, when -- do you remember
21 around when the time was that you were
22 included?
23 MS. KASSEL: I believe the
24 announcement came in the State of the State

1 address in 2011, and we put out our statement
2 shortly thereafter to say we were not aware
3 that any consumer advocates or consumers
4 themselves were on it, and the call came
5 immediately.
6 SENATOR RIVERA: And I'm sure -- I
7 would assume that you would want to -- again,
8 maybe not you personally, but that you
9 believe consumer representation in whatever
10 they've managed to put together is absolutely
11 essential for the product to be responsive to
12 the concerns of consumers.
13 MS. KASSEL: It is absolutely
14 essential. It would be a travesty for the
15 same process that happened in January and
16 February of 2011 to happen again.
17 SENATOR RIVERA: Thank you so much for
18 your time.
19 Thank you, Madam Chair.
20 CHAIRWOMAN WEINSTEIN: Thank you.
21 Thank you for being here.
22 Next we have the Pharmacists Society
23 of the State of New York, followed by the
24 Pharmaceutical Care Management Association,

1 followed by Community Pharmacy Association of
2 New York State.
3 MS. ENNELLO-BUTLER: Good evening,
4 Senators and Assemblymembers and
5 distinguished members of the Legislature. My
6 name is Deanna Butler, and I am the executive
7 director of the Pharmacists Society of the
8 State of New York, PSSNY. I'm here today
9 with PSSNY's president, Steve Moore, who is a
10 licensed pharmacist and co-owner of an
11 independent pharmacy in Plattsburgh,
12 New York.
13 Thank you for allowing PSSNY to
14 testify today. It is important to recognize
15 the support that the leaders and members of
16 both houses have shown for the issues that
17 PSSNY has brought to you in the past. Thank
18 you for recognizing the value that local
19 pharmacists bring to your communities and to
20 their patients. Many of your constituents
21 rely on the community pharmacists they know
22 and trust for medications as well as the
23 additional support and extra services we
24 provide.

1 Without rehashing the discussions
2 already held today, it is the position of
3 PSSNY that pharmacists must be adequately
4 represented on the MRT II. While not
5 originally included in the first MRT,
6 pharmacists are the most acceptable
7 healthcare providers capable of improving
8 patient outcomes and lowering costs.
9 MR. MOORE: We are here again today to
10 call on you with an even greater sense of
11 urgency. Just last year, this Legislature
12 passed what was called the strongest PBM
13 regulation bill in the country. As we know,
14 on December 26th it was vetoed. Now New York
15 remains unprotected from PBM profiteering and
16 lags behind other states who have already
17 begun to crack down on the PBM abuse of
18 patients, of providers, and of taxpayers.
19 The Executive has proposed a health
20 budget with four parts related to pharmacy.
21 Part G deals with prescription drug pricing
22 and an accountability board. We feel that
23 that could be successful, but only as a
24 complement to strong PBM reform. Without PBM

1 regulation, this proposal is not able to
2 address the root cause of rising prescription
3 drugs. And additionally, limiting the
4 board's ability to only investigate drugs
5 which have increased by 100 percent, may
6 hinder the board's effectiveness.
7 Part H of the Executive's proposal
8 deals with expansion of assistance for
9 licensed pharmacists. PSSNY supports this
10 ratio, and as we know, last year New York
11 State expanded the use of unlicensed persons
12 and created a registered pharmacy technician
13 class. The Governor now proposes expanding
14 the pharmacist ratio from four to six, while
15 also clarifying that registered pharmacy
16 technicians can perform additional duties
17 under the supervision of a licensed
18 pharmacist in all practice settings.
19 PSSNY supports this practice-side
20 parity, but we do have some concerns about
21 the ratio increase from four to six.
22 Part I deals with pharmacy adult
23 immunization expansion and collaborative drug
24 therapy management. New York is currently

1 one of four states to restrict the vaccines a
2 pharmacist can provide, and PSSNY supports
3 the expansion of this administration of all
4 CDC-recommended vaccines. We also suggest
5 that the Legislature accept the expansion of
6 CDTM from a demonstration program through
7 teaching hospitals to a program that's
8 available to all of New Yorkers.
9 Part U. PSSNY would suggest that the
10 Legislature modify the Governor's proposal
11 for PBM regulation. It's a solid foundation
12 for New York State; however, we've been here
13 before. On its own, the proposal is not
14 adequate to fully rein in PBM practices. We
15 feel compelled to reiterate that this
16 Legislature has previously passed what was
17 considered the most robust PBM reform measure
18 in the country.
19 PSSNY believes that PBM reform must
20 contain clear statutory language that
21 eliminates spread pricing in commercial
22 plans. PBM reform has been discussed by the
23 Executive, DFS, and the Senate for a number
24 of years now. How many pharmacies will have

1 to close, how many patients will have to be
2 manipulated, and how much more profit will
3 New York allow to these Fortune 25
4 corporations at the expense of its own
5 constituents?
6 Thank you for your time.
7 CHAIRWOMAN WEINSTEIN: Thank you. We
8 have -- Senator Rivera has a question?
9 SENATOR RIVERA: Yes, ma'am.
10 Good evening -- because now it is
11 actually evening, thank you for sticking
12 around. So just for the record, have you --
13 has the Pharmacists Society of the State of
14 New York been contacted by anyone in the
15 administration regarding your potential
16 participation in the MRT process?
17 MR. MOORE: Yes, we did discuss --
18 SENATOR RIVERA: Whoa, whoa, hold
19 it --
20 MR. MOORE: We did discuss with DOH on
21 our stakeholder call last week that we feel
22 that pharmacists should be part of MRT II, we
23 were left out of the original one, and so
24 we --

1 SENATOR RIVERA: Hold on a second.
2 This is actually very interesting, because I
3 was just waiting for you to answer no and
4 moving on, but -- so did they reach out to
5 you, or you're saying that you have a
6 preset -- like that you were already having
7 a -- going to have a conversation about
8 something else, and then you brought it up?
9 MR. MOORE: Yes, so we -- as part of
10 our monthly stakeholder calls, we brought it
11 up as part of the agenda. And we were
12 contacted subsequently by DOH for a name, and
13 we provided the name of a PSSNY member who is
14 a community pharmacy owner from the Bronx,
15 Roger Paganelli, who we think --
16 SENATOR RIVERA: Yes.
17 MR. MOORE: -- would be a great
18 addition to the --
19 SENATOR RIVERA: Former president
20 of --
21 MR. MOORE: Past PSSNY president, yes.
22 SENATOR RIVERA: So you actually gave
23 them -- so we have, like, one potential
24 person. That's like -- so if it's Roger --

1 MR. MOORE: He's got --
2 SENATOR RIVERA: -- and, like, I guess
3 the Governor. So I guess we've got two dudes
4 so far.
5 MR. MOORE: If anybody could do it, it
6 would be Roger. You know that.
7 SENATOR RIVERA: No, I know Roger.
8 And Roger's --
9 MR. MOORE: If anyone could do it,
10 he's the guy.
11 SENATOR RIVERA: He's a good dude to
12 have in that room.
13 But I just -- but in all seriousness,
14 if there was at least some level of back and
15 forth -- that they'd -- so they called you
16 and they asked you whether you had a name to
17 suggest.
18 MR. MOORE: Yes. Like I said, we have
19 a monthly stakeholder call, and after the
20 Governor's budget talk we brought it up on
21 the stakeholder call and we said that
22 pharmacists would like to be included. And
23 they subsequently sent an email asking for
24 names.

1 SENATOR RIVERA: All righty. I'm
2 hoping that that is actually -- that actually
3 turns into something.
4 MR. MOORE: Fingers crossed.
5 SENATOR RIVERA: Yes. Thank you so
6 much for sticking around tonight.
7 Thank you, Madam Chair.
8 CHAIRWOMAN WEINSTEIN: Thank you.
9 We go to Assemblyman Cahill now.
10 ASSEMBLYMAN CAHILL: Hi, how are you.
11 MR. MOORE: Good, Assemblyman. How
12 about yourself?
13 ASSEMBLYMAN CAHILL: A couple of
14 things.
15 Have you had a chance to look at the
16 Governor's full proposal on pharmacy benefit
17 management regulations this year?
18 MR. MOORE: We have.
19 ASSEMBLYMAN CAHILL: And if you could,
20 in just a couple of words, summarize the key
21 points that you think are missing from that
22 proposal.
23 MR. MOORE: So there's a framework for
24 a solid proposal. We are concerned that the

1 Governor's proposal deals largely through --
2 deals with PBMs largely through regulation
3 rather than statute, where we feel some of
4 this should be put into statute.
5 You know, we thought that last year's
6 piece of legislation was excellent PBM
7 legislation, so anything that's not quite as
8 strong and as robust as that piece of
9 legislation is something that's going to be a
10 little disappointing.
11 ASSEMBLYMAN CAHILL: So the question
12 of regulation versus statute, because of the
13 uncertainty of regulation, because of the
14 ability to change regulation, because of the
15 enforcement ability behind having a
16 statute -- all those other aspects of it.
17 And also, you know, as we've heard
18 from advocates of the Governor's position,
19 there are many, many legal issues surrounding
20 this and many litigants surrounding this who
21 would like to come and litigate every aspect
22 of it, so regulation could present a problem
23 in that regard too, right?
24 MR. MOORE: That's my understanding.

1 Correct.

2 ASSEMBLYMAN CAHILL: So I just want
3 to -- one of the things that we raised with
4 the superintendent today, and that was part
5 of the original proposal by Senator Breslin
6 and Assemblyman Gottfried, was this
7 relationship that we said that a PBM should
8 have a duty towards pharmacists, towards
9 professionals, towards the professional
10 providers that they worked with.

11 Give me a little bit of your thought
12 on that, whether you think there should be
13 some legal relationship between the two of
14 you.

15 MR. MOORE: I would think, when you're
16 dealing with these large Fortune 25 companies
17 that are dealing with people's health, you
18 know, there -- I know that sometimes
19 prescriptions can unfortunately be treated as
20 a commodity, but it's important to remember
21 when we're making prescriptions -- you know,
22 filling prescriptions and making these
23 decisions -- we're dealing with people.

24 And they have an obligation. We as

1 pharmacists have an obligation, you know,
2 physicians have an obligation, other
3 healthcare providers have an obligation. If
4 the PBMs are going to be involved in the care
5 to the standard and to the degree to which
6 they are, they should have an obligation as
7 well.
8 ASSEMBLYMAN CAHILL: Now, you run an
9 independent pharmacy, correct?
10 MR. MOORE: I do.
11 ASSEMBLYMAN CAHILL: What percentage
12 of your business comes through -- filters at
13 some point through a PBM?
14 MR. MOORE: Probably about 99 percent
15 of it.
16 ASSEMBLYMAN CAHILL: Ninety-nine
17 percent of your business. So if the PBM
18 makes a decision and you have no recourse,
19 you're stuck with it. What does that mean to
20 your business?
21 MR. MOORE: It means we close our
22 doors.
23 ASSEMBLYMAN CAHILL: Close your doors.
24 Have there been instances where the

1 PBM has insisted that you charge a lower
2 price than you paid for a drug?
3 MR. MOORE: The clawback issue was
4 largely a circumstance of one particular PBM,
5 and we do not have a lot of that particular
6 payer in our area. I have seen it happen,
7 but it was not in my experience.
8 ASSEMBLYMAN CAHILL: And the
9 membership of your organization has seen it.
10 MR. MOORE: Yes, I can confirm that
11 it's happened. I did see it happen --
12 granted, I'm in a small town in upstate
13 New York -- on a limited basis. I did not
14 see it to the same degree that others did.
15 ASSEMBLYMAN CAHILL: And let's say
16 that something happens midyear where you have
17 been relying upon something that a PBM told
18 you was going to be the rule, and then
19 midyear they change that rule, and maybe they
20 even have the right to do so under a contract
21 that you have with them. But it really does
22 your business a great detriment.
23 What is your recourse right now if
24 your contract says that's what you've got to

1 do?

2 MR. MOORE: We have no recourse for

3 any issue with a PBM at this point.

4 ASSEMBLYMAN CAHILL: And your

5 customers, the patients who come in and see

6 you, they often present you with an insurance

7 card and oftentimes they have a copayment

8 that is included with the price of -- you

9 know, included with the cost of the drug to

10 them.

11 If there is a price on that drug -- I

12 only expect a couple of numbers here, we'll

13 forget the dispensing fees and all that. The

14 drug is $15, the copay is $10, and the rebate

15 on that drug that might inure to the benefit

16 of the PBM is $11. Does that customer pay $4

17 or $5?

18 MR. MOORE: And so, interestingly

19 enough --

20 ASSEMBLYMAN CAHILL: Or $10?

21 MR. MOORE: What the customer pays is

22 now -- it now depends on where they sit in

23 regard to their deductible. We're finding

24 that when a customer is within their

1 deductible period, they're paying a higher
2 amount for their prescription than the PBM
3 subsequently pays when the patient reaches
4 their deductible and the PBM is responsible
5 for the payment.
6 ASSEMBLYMAN CAHILL: Right. So again,
7 the statute that Assemblyman Gottfried and
8 Senator Breslin proposed had a duty of care
9 also to the patient. Do you think there's
10 validity to having such a thing?
11 MR. MOORE: Absolutely.
12 ASSEMBLYMAN CAHILL: Okay. We have a
13 lot more questions on this, but I thank you
14 for continuing to run a community pharmacy,
15 and I thank you for your answers here today.
16 MR. MOORE: Thank you.
17 CHAIRWOMAN WEINSTEIN: Thank you.
18 Assemblyman Garbarino.
19 ASSEMBLYMAN GARBARINO: Thank you,
20 Madam Chairwoman.
21 How are you?
22 MR. MOORE: Good. How about yourself?
23 ASSEMBLYMAN GARBARINO: A quick
24 question. You suggest in your testimony that

1 the Legislature modify the drug
2 accountability board, the proposal. What
3 would you like to see? Like what
4 modifications would you like to see?
5 MR. MOORE: I guess by "modify" we
6 feel that that's only going to be effective
7 coupled with strong PBM reform. We feel PBMs
8 are still pervasive in the pricing issues
9 that we're experiencing.
10 You know, when you have Pharma and
11 drug companies talking about how they have to
12 adjust their practices because of the way
13 PBMs structure their rebate programs -- and
14 I'm not absolving Pharma of, you know,
15 pricing issues, but at the same time I just
16 feel that we need robust PBM reform to make
17 sure that that's effective. Much like we
18 need robust PBM reform to make sure that
19 issues like our MAC law are effective, issues
20 like our AMMO law are effective. We know
21 that we pass those and they don't work as
22 intended here in New York.
23 ASSEMBLYMAN GARBARINO: You think --
24 you said possibly modifying the 100 percent

1 increase -- what would you -- is it something
2 over a couple of years? Is it a lower amount
3 in one year --
4 MR. MOORE: It's probably a
5 combination of something over a couple years
6 versus a big increase over a period.
7 You know, you can have legitimate
8 instances -- Hurrican Sandy a few years ago,
9 where plants were destroyed here in New York,
10 you know, the price went up. Did the price
11 have to stay up once the stuff came back on
12 board and, you know, manufacturing was able
13 to catch up? Not necessarily.
14 You kind of limit yourself with
15 100 percent, I think, with something like
16 that.
17 ASSEMBLYMAN GARBARINO: Thank you.
18 CHAIRWOMAN WEINSTEIN: Thank you for
19 being here.
20 MR. MOORE: Thank you for having us.
21 CHAIRWOMAN WEINSTEIN: Next we have
22 the Pharmaceutical Care Management
23 Association, Lauren Rowley, vice president,
24 to be followed by the Community Pharmacy

1 Association of New York State.
2 MS. ROWLEY: Good evening, Chairwoman
3 Weinstein and Chairman Rivera. My name is
4 Lauren Rowley, I'm with the Pharmaceutical
5 Care Management Association. I appreciate
6 very much the opportunity to be here once
7 again before this committee to provide
8 testimony on behalf of the pharmaceutical
9 benefit managers, the PBMs of New York.
10 PBMs administer prescription drug
11 plans for more than 266 million Americans
12 nationally. In New York, we administer
13 prescription drug plans not just on behalf of
14 health plans, but for hundreds of self-funded
15 unions, school boards, municipalities, and
16 employers across this state.
17 I think it's important to note that
18 not one these entities have to hire a PBM.
19 The Medicare did not have to hire a PBM --
20 Medicaid. This NYSHIP, they do, because
21 we're the one entity in the supply chain that
22 has one job to do, and that is to hold down
23 the cost of prescription drugs.
24 As the attached article in your

1 materials show, our ability to provide
2 services effectively has real-life
3 implications for individuals in your
4 communities. PBM management is the
5 difference between unions and school
6 districts being able to manage prescription
7 drug benefits within their budgets or being
8 forced to make difficult choices.
9 PCMA does not oppose licensure and
10 regulation and certain levels of
11 transparency. In fact, we believe that there
12 should be transparency for all actors in the
13 drug supply chain, including pharmacies,
14 PSAOs, and Pharma. But we also believe very
15 strongly that budget policy decisions should
16 be made on objective data.
17 For example, the narrative that PBMs
18 are putting independent pharmacists out of
19 business in New York is false, and objective
20 data bears this out. According to
21 independent data from Quest Analytics
22 analyzing NCPDP data, the number of
23 independent pharmacies in New York increased
24 from 2,185 pharmacies in 2010 to 2,813 in

1 2019. That is a 29 percent increase in the
2 number of independent pharmacies.
3 Conversely, chain pharmacies at the
4 same time in 2010 had 2,079 pharmacies, down
5 from -- I mean today, I'm sorry, they have
6 2,079 pharmacies down from -- I mean, up
7 to -- down from 2,236 pharmacies. So really,
8 chain pharmacies are going out of business at
9 a much more rapid rate than independent
10 pharmacies.
11 I want to take one second to talk
12 about PSAOs, because I think one of the
13 things when you talk about middlemen, it's
14 always PBMs -- PSAOs are actually the
15 entities that contract -- 90 percent of the
16 contracts that are signed by PBMs with
17 independent pharmacies are done through a
18 middleman called a PSAO. So they are a very
19 relevant entity within the chain of drug
20 supply that have not been discussed.
21 They're the ones that are tasked with
22 negotiating contracts with PBMs. In
23 addition, they're generally wholesalers who
24 supply the drugs to the independent

1 pharmacies.

2 Regarding the Medicaid budget deficit,
3 when the pharmacy benefit was carved into
4 managed care under MRT I, PBMs helped save
5 the state and federal government an estimated
6 $200 million per year, according to DOH's
7 estimates.

8 PCMA and our member companies look
9 forward to continuing our work with the state
10 to help it meet its fiscal and policy goals,
11 and it's eager to help the state find
12 solutions to address the current Medicaid
13 budget deficit. We believe there is an
14 opportunity to produce immediate savings
15 through better fraud, waste and abuse
16 oversight, and we look forward to discussing
17 these with you and the MRT.

18 I am happy to answer the questions I'm
19 sure I'm going to get.

20 CHAIRWOMAN KRUEGER: Senator Rivera.

21 MS. ROWLEY: Senator Rivera, my answer
22 is no, we have not been contacted to
23 participate. We would welcome the
24 opportunity.

1 SENATOR RIVERA: I just have to check.
2 Thank you, Madam Chair.
3 CHAIRWOMAN KRUEGER: Assemblymember
4 Cahill.
5 ASSEMBLYMAN CAHILL: Thank you.
6 Are you glad we didn't do a panel like
7 we did last year?
8 MS. ROWLEY: I was kind of looking
9 forward to the cagefight again this year.
10 (Laughter.)
11 ASSEMBLYMAN CAHILL: We sold tickets
12 last year for it.
13 A couple of questions, more about how
14 your organization came to advocate for or
15 against the particular form of regulation of
16 PBMs. And last year you issued a memorandum
17 against the Gottfried-Breslin bill. Do you
18 remember when that memo was published?
19 MS. ROWLEY: I don't recall exactly
20 when that was published.
21 ASSEMBLYMAN CAHILL: And how do you
22 arrive, in your organization, at your
23 decision to issue a memorandum in support or
24 opposition? Does the staff make that

1 decision on their own, or do the member
2 organizations participate in that
3 decision-making?
4 MS. ROWLEY: It's done with the
5 members' participation.
6 ASSEMBLYMAN CAHILL: And is it a
7 majority vote? Or different all the time?
8 MS. ROWLEY: There are also
9 fundamental things that PCMA stands for with
10 regard to legislative principles that are
11 pretty well known.
12 But yeah, generally speaking, the
13 actions in the state are driven by its
14 members.
15 ASSEMBLYMAN CAHILL: I'm sorry, I lost
16 you --
17 MS. ROWLEY: I'm sorry. The actions
18 of PCMA in the state is driven by its
19 members.
20 ASSEMBLYMAN CAHILL: Driven by its
21 members. And at the time the memo was issued
22 against the Gottfried-Breslin bill, was
23 CVS Caremark a member of your organization?
24 MS. ROWLEY: They were, and they are.

1 ASSEMBLYMAN CAHILL: And did they
2 participate in the decision-making that led
3 to the decision to oppose the
4 Gottfried-Breslin bill?
5 MS. ROWLEY: They were unable to do
6 so. PCMA actually represents 18 PBMs. There
7 are 66 PBMs across the country, and we have
8 18, many of which are represented here in
9 New York.
10 ASSEMBLYMAN CAHILL: Yeah. So are any
11 members of Caremark serving on your board?
12 MS. ROWLEY: Yes.
13 ASSEMBLYMAN CAHILL: Okay. So who is
14 that? In what position?
15 MS. ROWLEY: John Roberts does -- I'm
16 assuming you're talking about the board of
17 directors of PCMA?
18 ASSEMBLYMAN CAHILL: Yes.
19 MS. ROWLEY: Yes. John Roberts from
20 CVS Health.
21 ASSEMBLYMAN CAHILL: So how did that
22 work? Did CVS recuse -- did they walk away
23 from the discussion? Did they say, We can't
24 take a position? Or did they say, We would

1 support -- we have to support this, because
2 that's the commitment we made when we got
3 permission to combine with Aetna, and we
4 signed an agreement to that effect?
5 MS. ROWLEY: I believe CIGNA also did,
6 and they're also a member of ours. They did
7 not participate with our other New York
8 members during our activities here with
9 regard to the Governor's budget last year.
10 ASSEMBLYMAN CAHILL: Okay. Well,
11 thank you very much for that.
12 You've seen -- and just -- I'm sorry
13 if I didn't catch it when you testified --
14 you've seen the Governor's proposal. Is it
15 something that you are supportive of?
16 MS. ROWLEY: We have some concerns --
17 I think the similar concerns that we shared
18 last year with the wide discretion of the
19 superintendent in certain areas, especially
20 the code of conduct areas. So we -- but we
21 look forward to working through those,
22 hopefully, with the Legislature and with the
23 Governor.
24 ASSEMBLYMAN CAHILL: Mr. Gottfried

1 couldn't be here, he had another obligation,
2 but I know that he was very concerned in his
3 questioning of a previous witness about the
4 duty-of-care provisions that were included in
5 his bill but are not included in the
6 Governor's bill. And the way he phrased it
7 is: Do you believe that PCMs should have a
8 duty of care to patients? Do you believe
9 that PCMs should have a duty of care to
10 providers?
11 So what is the position of your
12 organization in that regard?
13 MS. ROWLEY: So specifically on the
14 fiduciary mandate, we are opposed to that.
15 That's actually been litigated, and we were
16 successful in overturning that in D.C.
17 several years ago, as being preempted by
18 federal law.
19 We have a concern, we did offer
20 language, you know, good faith and fair
21 dealing with regards to the contracts the
22 PBMs sign with their clients. We are -- the
23 obligation of a PBM is fully laid out within
24 the contract that a PBM has with its

1 respective clients, so they -- you know, they
2 can always sue us under a breach of contract,
3 and we've seen cases where that's --
4 ASSEMBLYMAN CAHILL: I only have a
5 couple of seconds left, and I don't mean to
6 interrupt you, but you specifically said duty
7 of care to your clients. But the question
8 was about duty of care to consumers, to the
9 public, to patients, and to providers.
10 Does your contract specify those
11 things for those entities?
12 MS. ROWLEY: Within the contracts that
13 we have with our health plans, absolutely.
14 All of that is laid out, the duty of care
15 that a PBM must -- you know, performance
16 guarantees, the adherence, the drug
17 utilization review, all of the things that a
18 PBM does.
19 Keep in mind that the health plans are
20 the ones that are collecting the premiums
21 from the patients. PBMs do not touch the
22 patients in that way, they administer the
23 benefit on behalf of the health plans who
24 administer -- who define the benefit --

1 ASSEMBLYMAN CAHILL: Well, again, I
2 would have to differ with you a little bit on
3 whether the PBMs have a direct influence and
4 a direct contact with patients. I think they
5 have a very significant and pervasive
6 relationship with patients.
7 But thank you for your testimony, and
8 I think if it's good enough for your
9 contract, it ought to be good enough for the
10 law.
11 MS. ROWLEY: And just -- I know you
12 didn't ask it, but you did for somebody else.
13 You asked a question regarding a PBM's
14 obligation to a pharmacy, and those also are
15 driven by the contracts that are signed,
16 which is why I think this legislative body
17 should consider looking at PSAOs.
18 I think it's a serious issue. We've
19 tried to raise that in other states, and
20 it's -- they're the ones that are actually
21 negotiating the contracts on behalf of the
22 independent pharmacies.
23 CHAIRWOMAN KRUEGER: Thank you.
24 Assemblymember Garbarino.

1 ASSEMBLYMAN GARBARINO: Thank you.
2 You just started my question. PSAOs, what --
3 can you get into that? I really don't -- you
4 mentioned them a couple of times, and I'm not
5 really exactly sure --
6 MS. ROWLEY: They're pharmacy services
7 administrator organizations, and they're paid
8 for by the pharmacists who contract with
9 them.
10 And basically they're little
11 companies -- not really, they're Fortune 20
12 companies like AmerisourceBergen, Cardinal
13 Health, and several others. There's also
14 smaller PSAOs that independent pharmacists
15 will contract with.
16 And their job is to work with the
17 pharmacists to help them with Medicaid and
18 Medicare, their contract obligations.
19 They're the ones that negotiate the contracts
20 on behalf of their clients, so maybe they
21 have 800 independent pharmacies that they
22 work with, that they'll negotiate the
23 contracts with the PBMs.
24 They also often -- as I mentioned

1 AmerisourceBergen and Cardinal, they're
2 wholesalers, so they also sell drugs to the
3 pharmacists. We -- PBMs have no visibility
4 whatsoever to the contracts that the PSAO has
5 with their pharmacy clients. Those are
6 obviously proprietary between those two
7 entities, but they're not really looked at.
8 And I think when we're being blamed for all
9 these contracting issues, I think that that's
10 an important element that hasn't been
11 discussed.
12 ASSEMBLYMAN GARBARINO: So you
13 contract with the PSAO, is that how it works?
14 MS. ROWLEY: The PSAO will sign a
15 contract on behalf of the independent
16 pharmacist.
17 CHAIRWOMAN KRUEGER: Okay? Thank you.
18 Assemblymember Byrne.
19 ASSEMBLYMAN BYRNE: Thank you.
20 I'm looking at this article that you
21 reference in your testimony about the -- I
22 hope I'm pronouncing this right -- the
23 Voorheesville School District. And I'm just
24 trying to follow a little bit, because it

1 looks like they had a PBM and they still
2 didn't get savings. Can you just explain
3 that a little bit --
4 MS. ROWLEY: Sure.
5 ASSEMBLYMAN BYRNE: -- about how that
6 would happen?
7 MS. ROWLEY: So originally they had
8 like an open formulary, so they didn't use
9 PBM tools.
10 And one of the major reasons PBMs are
11 utilized is because of being able to use
12 prior authorization and step therapy and
13 things that -- controlling costs, and
14 preferring generic drugs, for instance, over
15 branded drugs. And then the competition of,
16 you know, formulary placement and those types
17 of things.
18 So when they started using formulary
19 tools, they actually saw a significant
20 savings.
21 ASSEMBLYMAN BYRNE: Okay. Now, you
22 also mentioned in your testimony here that
23 PCMA believes that there should be
24 transparency for all actors in the drug

1 chain. Now I'm hearing you saying you want
2 transparency -- can you explain a little bit
3 about what you mean within the drug chain,
4 all these other entities, can you elaborate
5 on that a little bit?
6 MS. ROWLEY: Yeah, I mean, my
7 understanding is that all providers in
8 Medicaid, for instance, have an obligation to
9 report -- to submit cost reports that
10 pharmacies do not.
11 Transparency exists between PBMs and
12 their clients. Any level of pass-through
13 is -- again, PBMs will bid on contracts with
14 their clients, and if the clients say we want
15 100 percent pass-through of all rebates, they
16 get that. They can audit the PBM to ensure
17 that they're getting that.
18 I think that there's some transparency
19 issues relative to Pharma that should be
20 discussed, and of course the PSAOs which I've
21 already mentioned.
22 ASSEMBLYMAN BYRNE: Okay. Thank you.
23 CHAIRWOMAN KRUEGER: Okay. Thank you
24 very much for your testimony here tonight.

1 It's appreciated.
2 Next we have the Community Pharmacy
3 Association of New York State, Diane
4 Lawatsch -- she will pronounce it correctly
5 when she gets up.
6 Thank you.
7 MS. LAWATSCH: Good evening.
8 CHAIRWOMAN KRUEGER: Good evening.
9 MS. LAWATSCH: Good evening. My name
10 is Diane Lawatsch, like "watch" --
11 CHAIRWOMAN KRUEGER: Thank you.
12 MS. LAWATSCH: -- and I am an officer
13 of the Community Pharmacy Association of
14 New York, and I'm a licensed pharmacist at
15 Wegman's Food Market.
16 Thank you for your strong past support
17 of community pharmacy in New York and for the
18 opportunity to testify today related to the
19 state fiscal year 2020-'21 State Budget. In
20 our written comments that have been
21 submitted, we comment on six Executive Budget
22 proposals. I will briefly summarize the top
23 priority areas today.
24 First, we are very concerned about the

1 1 percent across-the-board Medicaid cut
2 enacted January 1st, along with the
3 possibility of further cuts as the result of
4 the proposed MRT II process.
5 Community pharmacy has seen very
6 significant cuts over the last several years,
7 namely due to the move of the state's
8 Medicaid pharmacy benefit of managed care for
9 most beneficiaries. Pharmacies are now paid
10 at or below their actual costs by
11 managed-care plans and their pharmacy benefit
12 managers. This model is untenable, and there
13 is no ability to sustain any further cuts.
14 In fact, as it relates to all of our
15 payers -- and speaking on behalf of my
16 pharmacy -- managed Medicaid is at or below
17 our cost of dispensing 90 percent of the
18 time. As a pharmacist for the past 30 years
19 in New York State, it is incredibly
20 disheartening to watch this trend.
21 When discussing the Medicaid
22 shortfall, the Governor stated that there
23 should be zero impact to beneficiaries. This
24 is very important, but it's also critical

1 that the administration understand that cuts
2 to services will impact beneficiaries and
3 cuts to struggling pharmacies will impact
4 beneficiaries as we work to remain open and
5 provide high-quality pharmacy services for
6 our patients.
7 We're asking for a seat at the table
8 for MRT II and have made this request of the
9 administration. We were not approached, but
10 we have asked. We have also asked that the
11 state reconsider the 1 percent reduction, and
12 we ask for your help to prevent any further
13 cuts to pharmacy care for the patients we
14 serve.
15 Secondly, we strongly support the
16 Executive Budget proposal related to
17 pharmacist-administered immunizations. Since
18 2008, pharmacists have been providing
19 immunizations in New York. The current law
20 expires this year, and the Executive Budget
21 makes pharmacist immunization authority
22 permanent for all CDC-recommended vaccines
23 for adults.
24 It is in the best interest of the

1 state and public health overall to ensure
2 that patients have seamless access to
3 vaccinations seven days a week, including
4 evenings and weekends. Because pharmacists
5 currently lack the authority to give all
6 CDC-recommended vaccines for adults,
7 pharmacists have had to turn patients away.
8 This includes adults seeking the measles
9 vaccine last year during the height of the
10 outbreak in New York.
11 With vaccines for a patient who needs
12 and is interested in getting a vaccine, we
13 strongly urge New York to join nearly all
14 other states by allowing pharmacists to
15 administer all adult vaccines and to make
16 this law permanent in the final budget.
17 We want to voice our support for
18 licensing and regulating pharmacy benefit
19 managers. This action is urgently needed to
20 protect patients, pharmacies, and other
21 providers against unfair and in some cases
22 abusive practices. We are asking for
23 immediate action to ensure state oversight
24 over PBMs, and I know my colleagues at PSSNY

1 have already spoken to you in great detail on
2 this.
3 Finally, we support the budget
4 proposal to recognize registered pharmacy
5 technicians across pharmacy settings and
6 discuss other ways that pharmacists can add
7 value, improve outcomes, and reduce costs
8 through comprehensive medication management
9 in our written testimony.
10 Thank you for your consideration of
11 our comments as we work to ensure patient
12 access to high-quality pharmacy and related
13 care throughout the state. Please continue
14 to see us as a resource of any medication or
15 healthcare topic where we can provide
16 assistance.
17 Thank you.
18 CHAIRWOMAN KRUEGER: Great. Senate?
19 Assembly?
20 ASSEMBLYMAN GARBARINO: One more
21 question.
22 CHAIRWOMAN KRUEGER: Yes.
23 ASSEMBLYMAN GARBARINO: So I just
24 heard of the PSAOs today for the first time.

1 So can you explain a little more what that
2 is? Do you use PSAOs?
3 MS. LAWATSCH: We do not use a PSAO.
4 So a PSAO is typically used by a group
5 of pharmacists, so that they have a
6 representative to be the go-between between
7 the PBM and their group of pharmacies. So
8 that's why groups of independent pharmacies
9 traditionally have that.
10 We do our own contracting and
11 negotiating with the PBMs.
12 ASSEMBLYMAN GARBARINO: So your people
13 that are part of your organization, they deal
14 directly --
15 MS. LAWATSCH: People who are --
16 correct. True statement.
17 ASSEMBLYMAN GARBARINO: So you don't
18 use PSOAs at all.
19 MS. LAWATSCH: We do not.
20 ASSEMBLYMAN GARBARINO: Okay. Thank
21 you.
22 CHAIRWOMAN KRUEGER: Thank you very
23 much for your joining us tonight.
24 MS. LAWATSCH: Great. Thank you.

1 CHAIRWOMAN KRUEGER: Thank you.
2 Okay, next up -- I think we're done
3 with the pharmacy organizations -- we have
4 the Agencies for Child Therapy Services,
5 Children's Therapy Services, followed by the
6 Children's Defense Fund, followed by
7 Coalition Against Trafficking of Women.
8 And this is a test: How many of us up
9 here recognize Steve Sanders, previously of
10 the Assembly, previously my -- an overlapping
11 Assembly member of mine in Manhattan?
12 EXEC. DIR. SANDERS: And the answer to
13 that question is dwindling every year, I've
14 noticed.
15 (Laughter.)
16 CHAIRWOMAN WEINSTEIN: It's nothing
17 personal, Steve.
18 (Laughter.)
19 MR. SANDERS: I'm delighted to be here
20 again. Thank you very much, Chair Liz
21 Krueger, Chair Gustavo Rivera, and Chair
22 Kevin Cahill and members of the Assembly and
23 the Senate --
24 CHAIRWOMAN WEINSTEIN: (Loudly

1 clearing throat.)
2 MR. SANDERS: As I've been sitting
3 here -- excuse me?
4 CHAIRWOMAN WEINSTEIN: Hi.
5 (Laughter.)
6 MR. SANDERS: Oh, excuse me. Okay,
7 I'm done.
8 (Laughter.)
9 MR. SANDERS: I'm really done now.
10 (Laughter.)
11 CHAIRWOMAN KRUEGER: Didn't you
12 overlap with Helene when you were here?
13 MR. SANDERS: Yes, as a matter of --
14 yes, we were about 20 feet -- offices
15 separated by about 20 feet. And I actually
16 arrived two years before Helene did, just a
17 little bit before her dad did, and we served
18 together for a couple of years.
19 I'm really honored to be here again
20 with all of you. And as I was sitting and
21 listening to the testimony, listening to the
22 questions, it struck me that most health-cost
23 questions are complicated, but with Early
24 Intervention -- and that's what I'm here to

1 talk about for three or four minutes. But
2 with Early Intervention, the answer is really
3 simple.
4 So the Governor in his Executive
5 presentation correctly identified the
6 problem. What he said was that the problem
7 with Early Intervention funding is that
8 commercial insurance is simply not paying
9 their fair share. They don't now, they never
10 have. And to illustrate that point, the
11 Governor iterated some very interesting
12 statistics, all of which are true. He
13 indicated that of the total $700 million of
14 reimbursement to Early Intervention
15 providers, commercial insurance pays
16 2 percent. Of the claims that are submitted
17 to commercial insurance, they approve
18 15 percent of the claims and reject
19 85 percent of the claims.
20 Contrast that with Medicaid,
21 government insurance. Medicaid approves
22 almost 75 percent of the claims, while
23 commercial insurance is denying about
24 85 percent of the claims.

1 So the problem with Early Intervention
2 was clearly identified by the Governor -- the
3 funding with Early Intervention, clearly
4 identified by the Governor, but he doesn't
5 come up with the right answer. The only
6 additional dollars that the Governor
7 recommends in the Article VII language
8 amounts to about $1.6 million when
9 annualized. It's called pay and pursue,
10 which Kevin Cahill had a little dialogue with
11 the commissioner earlier today.
12 That is not the answer. Everything
13 that this Governor has tried to do -- and he
14 has tried to do interesting things over the
15 years, as have his predecessors, to try to
16 get commercial insurers to pay their fair
17 share. Everything that they have tried to do
18 in the past has failed. Commercial insurers
19 20 years ago were paying 2 percent of the
20 grand total of $700 million; they're paying
21 2 percent of the grand total today.
22 The answer to that funding disparity,
23 which has to be made up -- whatever
24 commercial insurance denies, bear in mind the

1 state has to pay and the counties have to pay
2 equally, fifty-fifty. So the Assembly and
3 the Senate actually had the answer last year.
4 You put into your one-house budget bills
5 covered lives to include Early Intervention.
6 What's covered lives? It merely is a
7 an estimate, it's an assessment on the
8 industry as to what the industry should be
9 paying for a particular service. That is the
10 only way, we have learned -- through
11 experience, expensive experience -- that
12 commercial insurance will finally pay their
13 fair share of any health program, in this
14 case the Early Evaluation Program.
15 So the Governor lays out the problem
16 accurately. You have the answer. You had
17 the answer last year. I urge you to, in your
18 one-house bills, to replicate what you did
19 last year, which is to include Early
20 Intervention under covered lives.
21 I would just close by saying this. At
22 this moment in time with this budget, when
23 the question of how to find savings in the
24 health-cost area is so prominent, why would

1 we not want to insist that commercial
2 insurance pays its fair share and save the
3 state and counties what would be tens of
4 millions of dollars each year? I think you
5 should ponder that question. And as you do,
6 I think you will come up with the answer you
7 did last year: Include Early Intervention
8 under covered lives, save the state and
9 counties tens of millions of dollars, and
10 finally have commercial insurers pay their
11 fair share.
12 Thank you very much for the
13 opportunity, I appreciate it.
14 CHAIRWOMAN WEINSTEIN: Thank you.
15 MR. SANDERS: Hello, Helene.
16 (Laughter.)
17 CHAIRWOMAN KRUEGER: Senators?
18 Assemblymembers?
19 CHAIRWOMAN WEINSTEIN: Assemblyman
20 Cahill.
21 ASSEMBLYMAN CAHILL: Steve, I remember
22 you when you used to have white hair -- wait.
23 Yeah, you still do.
24 (Laughter.)

1 ASSEMBLYMAN CAHILL: One of my
2 concerns with solving this problem is that we
3 might not see you next year in the evening at
4 the budget hearing. But I'm sure you'll find
5 another cause between now and then.
6 Can you give me some thoughts as to
7 why maybe this is not happening, because it
8 truly seems to most people like a no-brainer.
9 The ones you can say in public.
10 MR. SANDERS: I -- I cannot. All I
11 can tell you is that there was a mighty
12 effort that was made to reconfigure the
13 reimbursement and the funding system of
14 Early Intervention back in 2013.
15 I'll just take one moment to remind
16 you what it looked like before 2013. The
17 counties were responsible for paying
18 providers, and it was the counties'
19 responsibility to recover as much money from
20 commercial insurance as they could. The
21 counties hated doing that. Why? Because
22 they couldn't get any money from commercial
23 insurance. So the counties wanted out.
24 And I can understand why they wanted

1 out. It was a lot of administrative cost to
2 them, they weren't getting anything back from
3 commercial insurers, and they were paying
4 providers up-front.
5 So the state decided to hire a fiscal
6 agent who would act as the intermediary
7 between providers and the insurance world,
8 take counties out of the process of doing the
9 billing to commercial insurance, and the
10 hope, the stated hope was that with the
11 professional services of a fiscal agent, that
12 somehow that 2 percent total that commercial
13 insurance was paying of the Early
14 Intervention reimbursement would rise to
15 4 percent, 5 percent, 8 percent.
16 It never happened. I can't tell you
17 why. All I can tell you is that I think that
18 at every turn commercial insurance is very,
19 very good at finding ways and excuses not to
20 pay their fair share, certainly of Early
21 Intervention. I'm not going to comment on
22 any other program. But I've seen this now
23 for all the years that I have been executive
24 director of ACTS, and I saw it when I was in

1 the Legislature. They are very, very adept
2 at finding ways to evade and avoid their
3 responsibility.
4 ASSEMBLYMAN CAHILL: If I can
5 interrupt you just at that point.
6 MR. SANDERS: Yes, sir.
7 ASSEMBLYMAN CAHILL: So if the
8 insurance industry was willing to sit at the
9 table -- we heard today that Dr. Zucker is
10 prepared to sit at the table. You,
11 representing the providers, would be willing
12 to sit at the table. The Legislature has
13 already proposed it once, and we're ready to
14 propose it again.
15 Is there anything you see that would
16 stand in the way of us resolving it between
17 now and April 1st?
18 MR. SANDERS: Well, there's no logical
19 reason, there's no economic reason. It's a
20 win for the state, it's a win for the
21 counties, it's a win for providers because
22 they won't be burdened with this
23 administrative weight to have to bill
24 commercial insurance futilely, take weeks and

1 weeks and weeks to bill them, not to get the
2 money back, only to see the money being paid
3 back by -- ultimately by counties in the
4 state.
5 So it's a win for providers, it's a
6 win for the state, it's a win for counties.
7 And frankly, I think it's not too much to ask
8 that commercial insurance pay whatever the
9 Legislature determines ought to be their fair
10 share.
11 We're not asking to soak them. This
12 is not a soak the wealthy, soak the rich.
13 This is an industry that has a responsibility
14 to pay their fair share. That's all we ask.
15 ASSEMBLYMAN CAHILL: And I'm going to
16 suggest to you that it may also be a win for
17 the insurance companies, if it turns out that
18 they can do away with all the rigmarole
19 surrounding claim denial and processing.
20 MR. SANDERS: I would agree with that.
21 They have to adjudicate tens of thousands of
22 claims every year, and there's an
23 administrative cost to that for them as well.
24 So I am left without any answer to

1 your question as to what logical reason would
2 exist not to do what seems to be so obvious
3 to so many people.
4 ASSEMBLYMAN CAHILL: Your question
5 answers my question. Thank you.
6 MR. SANDERS: Thank you all for
7 listening. I appreciate it.
8 CHAIRWOMAN KRUEGER: Thank you, Steve.
9 Nice seeing you.
10 Next is the Children's Defense Fund,
11 followed by Coalition Against Trafficking in
12 Women, followed by New York State Health
13 Facilities Association.
14 MR. ANDERSON: Good evening.
15 CHAIRWOMAN KRUEGER: Good evening.
16 MR. ANDERSON: My name is Ben
17 Anderson. I'm the director of poverty and
18 health policy at the Children's Defense Fund
19 New York.
20 The Children's Defense Fund, CDF, is a
21 children's policy and advocacy organization.
22 We work nationally and across New York State
23 on a variety of health issues. Our written
24 testimony covers many of these issues, but I

1 want to focus my remarks today on just two of
2 them.
3 First is the Medicaid global cap. By
4 way of background, Medicaid is the foundation
5 of New York's children's health system. I
6 think as it was mentioned earlier, it serves
7 roughly 50 percent of New York's children --
8 that's over 2 million children in the
9 state -- and it serves our most vulnerable
10 children, those living in low-income
11 households, children with disabilities,
12 children in foster care who have been abused
13 or neglected.
14 And I just want to remind folks that
15 Medicaid is an entitlement program that
16 operates on a promise to these children, as
17 well as low-income adults, seniors and
18 individuals with disabilities, that if they
19 have health needs that are covered by the
20 program, that those services will be paid for
21 and they'll be paid for in an amount that
22 will ensure a sufficient number of providers
23 to meet the needs of the beneficiaries.
24 And the reason why we're here today --

1 or the reason why we have a hole in the
2 Medicaid budget, rather, is because we have
3 imposed a state cap that is operating the
4 exact same way that a federal block grant or
5 a per-capita cap would operate. Block grants
6 and per-capita caps are dangerous financing
7 mechanisms because they fail to properly
8 account for demographic changes, like a
9 surging elderly population. And they also
10 fail to account for higher costs of care that
11 are required to meet patient needs. They
12 also often fail to protect against population
13 health needs like epidemics or natural
14 disasters.
15 So at CDF we don't think anyone should
16 be surprised that the budget is in the
17 position that it's in today. And there's no
18 way to outrun this issue. As long as there
19 is a cap like the one we have today in place,
20 we will keep having this conversation over
21 and over again.
22 That means, I think, it's time to take
23 a serious look at the cap. One thing that we
24 know from the federal caps that have been

1 proposed is that they simply shift the burden
2 from the federal government to -- or would
3 shift the burden from the federal government
4 to the states, to counties, to beneficiaries,
5 to providers. And that's exactly what could
6 happen if the current cap remains in place.
7 Before I conclude, I also want to
8 briefly mention lead poisoning prevention.
9 CDF has been doing work in collaboration with
10 a number of partners across the state on this
11 issue. New York has more children with
12 elevated blood lead levels than any other
13 state in the U.S. In some parts of New York
14 City and New York State the rates of
15 childhood lead exposure are five to six times
16 higher than Flint, Michigan, at the peak of
17 its water crisis. And most children in New
18 York are exposed to lead from lead paint and
19 its dust in housing.
20 Programs to find and fix the lead
21 hazards in housing are woefully underfunded.
22 That is why, in addition to the $46 million
23 that is being requested by the counties, we
24 also support adding an additional $50 million

1 to find and fix lead hazards in housing, as
2 well as support primary prevention efforts in
3 other ways.
4 Thank you.
5 CHAIRWOMAN KRUEGER: Thank you.
6 Senate, anyone? We're good?
7 CHAIRWOMAN WEINSTEIN: We're good.
8 CHAIRWOMAN KRUEGER: Thank you very
9 much for coming and testifying.
10 MR. ANDERSON: Thank you.
11 CHAIRWOMAN KRUEGER: Next up is
12 Coalition Against Trafficking in Women,
13 followed by New York State Health Facilities
14 Association, followed by Primary Care
15 Development Corporation.
16 Good evening.
17 MS. SAVARESE: Good evening,
18 Chairperson Krueger --
19 CHAIRWOMAN KRUEGER: We need the mic
20 close to your mouth.
21 MS. SAVARESE: I'm sorry.
22 CHAIRWOMAN KRUEGER: Thank you.
23 MS. SAVARESE: Good evening,
24 Chairperson Krueger, Chairperson Weinstein,

1 members of the Assembly and the Senate.
2 Thank you very much for having me.
3 My name is Lynn Savarese. I'm here
4 today on behalf of the Coalition Against
5 Trafficking in Women, and I'm one of more
6 than 100 women's rights leaders who signed a
7 letter to Governor Cuomo last year urging him
8 to oppose the legalization of commercial
9 surrogacy in New York. Sadly, our letter
10 fell on deaf ears.
11 Since your last legislative session, I
12 have traveled the country interviewing women
13 who have suffered great harm as a result of
14 serving as commercial surrogates. You will
15 hear from some of them soon. The Governor's
16 proposal to legalize commercial surrogacy has
17 numerous failings, only a few of which I have
18 time today to discuss.
19 The greatest failing of the bill is
20 its lack of protections for women who would
21 serve as commercial surrogates. Nothing in
22 the bill prevents the targeting of vulnerable
23 women in dire need of money who lack the
24 means or the information to properly evaluate

1 the risks to their health that are inherent
2 in the surrogacy contracts sanctioned by the
3 bill.
4 These contracts are negotiated without
5 a semblance of equal bargaining power. On
6 the one hand, you have a young woman, usually
7 a mother of small children with no more than
8 a high school education who is in a
9 precarious financial situation. She has
10 little if any knowledge of the health risks
11 involved in a surrogacy pregnancy, which are
12 far more onerous than those associated with
13 the traditional pregnancies she may already
14 have experienced.
15 The temptation that commercial
16 surrogacy dangles before such a woman is
17 overwhelming. A $30,000 payment often
18 amounts to more than twice her annual income.
19 On the other side of the contract, you
20 have wealthy individuals with vastly greater
21 financial resources who can spend $150,000 or
22 more to procure a child.
23 Another failing of this bill is its
24 disregard for the well-being of surrogate

1 children. Under New York law, parents
2 seeking to adopt children must undergo
3 rigorous screening and background checks to
4 ensure their fitness. By contrast, the
5 Governor's bill requires no background check
6 or screening of any kind. In fact, nothing
7 in this bill prohibits convicted pedophiles
8 from purchasing surrogate children or wealthy
9 individuals coming from abroad from
10 purchasing a surrogate child or two dozen
11 surrogate children, and then taking them back
12 to his home country.
13 These are not hypotheticals but actual
14 cases detailed in attachments to my written
15 testimony.
16 New York State forbids the buying and
17 selling of organs. You rejected the argument
18 that a person has the right, for example, to
19 sell his kidney, even when it was shown that
20 in addition to receiving payment, he might
21 derive personal satisfaction from saving the
22 life of another. You rejected it because
23 human bodies are not to be bought and sold or
24 rented.

1 Identical arguments are being advanced
2 by the multi-billion-dollar surrogacy
3 industry. But unlike a kidney selling
4 agreement, a commercial surrogacy contract
5 saves no lives and instead puts the lives of
6 the surrogate mother and the children she
7 bears at risk.
8 Women who agree to be commercial
9 surrogates take on a far greater risk than
10 those faced in traditional pregnancies or
11 other types of in vitro fertilization
12 pregnancies. The required use of donor eggs
13 in surrogacy pregnancies dramatically
14 increases those risks.
15 I see that I'm running out of time,
16 and it's so -- I so regret it. Reproductive
17 medicine is one of the fastest growing and
18 most lucrative fields of medicine. But just
19 like the tobacco industry, which thwarted
20 research into harms to smokers for decades,
21 fertility experts have refused to conduct
22 research into the health risks for surrogate
23 women and their offspring.
24 Even if a would-be surrogate was

1 advised of all, quote, known risks, her
2 informed consent remains an impossibility
3 because those risks are unknowable. We know
4 that surrogate mothers in the United States
5 have died as a result of dangerous surrogacy
6 pregnancies, leaving their own young children
7 motherless.
8 New York State is the progressive
9 leader on so many vital public policy issues.
10 Your strong stance to protect women and
11 children by outlawing commercial surrogacy
12 contracts in the early '90s was true
13 progressive leadership. Undoing that legacy
14 would be a giant step backwards. I
15 respectfully urge you to reject Governor
16 Cuomo's misguided proposal.
17 CHAIRWOMAN KRUEGER: Questions?
18 Questions? Okay.
19 Thank you very much for your
20 testimony.
21 MS. SAVARESE: Thank you.
22 CHAIRWOMAN WEINSTEIN: Thank you for
23 being here, Lynn.
24 CHAIRWOMAN KRUEGER: Appreciate it.

1 Okay, next, the New York State Health
2 Facilities Association.
3 Good evening.
4 MR. HANSE: Good evening.
5 MS. PAPPALARDI: Good evening.
6 MR. HANSE: My name is Stephen Hanse,
7 and I have the privilege of serving as
8 president and CEO of the New York State
9 Health Facilities Association and the
10 New York State Center for Assisted Living.
11 Joining me this evening is Jackie Pappalardi.
12 Jackie serves as our executive director of
13 the foundation for Quality Care, our
14 education arm of NYSHFA/NYSCAL.
15 NYSHFA/NYSCAL is a statewide
16 organization representing over 400
17 proprietary, not-for-profit and
18 government-sponsored nursing homes and
19 assisted living facilities throughout the
20 state.
21 I believe that we would all agree that
22 a fundamental role of government is to care
23 for those who are unable to care for
24 themselves, and nowhere is this fundamental

1 role more evident than in Medicaid's
2 commitment to our elderly and frail
3 New Yorkers residing in nursing homes and
4 assisted-living facilities. This is a
5 commitment that New York has honored since
6 Medicaid was first established in 1965.
7 However, over the last 11 years, this
8 commitment has wavered, with the state
9 cutting nearly 1.9 billion from nursing
10 homes. At $55 per patient per day, New York
11 now unfortunately leads the nation with the
12 largest shortfall between the amount Medicaid
13 reimburses providers for care in a nursing
14 home and the actual cost of care.
15 And the most recent data shows that
16 the average operating margin for New York's
17 nursing homes was minus 1.3 percent, and
18 approximately 41 percent of New York's
19 nursing homes are operating at a loss.
20 Moreover, the state recently imposed a
21 1 percent across-the-board Medicaid cut,
22 directly impacting nursing homes and
23 assisted-living providers.
24 However, as we have heard today, when

1 we talk about long-term care, it's important
2 to recognize that nursing homes and
3 assisted-living providers and their
4 utilization is not what is driving the
5 Medicaid deficit. It is clear in the
6 Executive Budget documents that the shortfall
7 is not a result of institutional long-term
8 care. This is the case notwithstanding the
9 fact that nursing homes are caring for an
10 ever-increasing polychronic, high-acuity
11 population.
12 New York is also facing a healthcare
13 workforce crisis. As Assemblywoman Gunther
14 stated earlier today, nurses are the backbone
15 of healthcare. And as you also heard
16 earlier, 80 percent of nursing home costs are
17 directly attributable to employee wages and
18 benefits, and many of our employees are
19 represented by organized labor.
20 Given New York's nation-leading
21 insufficient Medicaid reimbursement rate,
22 nursing homes and assisted-living providers
23 are unable to compete with other healthcare
24 providers in their ability to recruit and

1 retain nursing staff.
2 Commissioner Zucker referenced earlier
3 New York's ever-increasing aging population
4 and that nursing home issues are very
5 different now, and those who represent
6 nursing homes and assisted-living providers
7 will be included in MRT II. This is in
8 contrast to the first MRT, on which nursing
9 homes and assisted-living providers were not
10 represented as stakeholders and, as such,
11 were subjected to almost $800 million in
12 direct cuts.
13 It is critical that nursing homes and
14 assisted-living providers be represented as
15 stakeholders on the MRT II.
16 In addition to our request to
17 participate as stakeholders on the MRT II,
18 NYSHFA and NYSCAL support strengthening
19 administrative resources and efficiencies at
20 the local government level to support the
21 state's Medicaid program. Many nursing homes
22 throughout the state are facing significant
23 delays in the processing of Medicaid
24 eligibility applications at local DSS

1 offices. For example, in Erie County alone,
2 providers are owed over $16 million as a
3 consequence of pending Medicaid applications.
4 NYSHFA/NYSCAL also supports maximizing
5 the state's savings that will be achieved by
6 moving long-term-care nursing home residents
7 from managed-long-term care back to fee for
8 service.
9 NYSHFA/NYSCAL also supports increasing
10 the ALP reimbursement rate and requests that
11 the state work in partnership with
12 assisted-living providers to provide care for
13 New York's growing homeless population.
14 As always, NYSHFA/NYSCAL looks forward
15 to continuing to work in partnership with the
16 Legislature, the Executive and all providers
17 to strengthen the state's fundamental role in
18 providing care to New York's elderly and
19 frail women and men in nursing homes and
20 assisted-living facilities throughout the
21 state.
22 Thank you very much for your time and
23 consideration.
24 CHAIRWOMAN KRUEGER: Thank you.

1 Questions? Senator Rivera.
2 MR. HANSE: Senator, we have not been
3 requested to serve on the MRT II. We would
4 welcome the opportunity to serve.
5 CHAIRWOMAN WEINSTEIN: Assemblyman Ra.
6 ASSEMBLYMAN RA: Thank you. Thank you
7 for your patience today.
8 I just wanted to get -- if you can
9 elaborate a little bit more about the
10 Certificate of Need surcharge and how it
11 would impact your members and their ability
12 to construct new facilities and make sure
13 they have adequate facilities. As you
14 mentioned, you know, the population has
15 different needs than maybe they did long ago,
16 and part of that is always changing
17 facilities to make sure the facilities are
18 able to meet those needs.
19 MR. HANSE: Sure. NYSHFA/NYSCAL
20 opposes the proposal in the budget to impose
21 CON fees. This is really founded in the fact
22 that New York's nursing home buildings are
23 primarily all -- have all been built in the
24 1960s and the early 1970s. The age of those

1 facilities is getting very old. Many
2 providers are submitting applications for
3 CONs to update their facilities.
4 I think the state's first brand-new
5 nursing home in I think at least nine years
6 was just opened in White Plains, and it is
7 beautiful. If you went there, you would
8 think it was a hotel.
9 So anything that would impede the
10 ability of providers to either update their
11 facilities or construct new ones, we would
12 oppose.
13 ASSEMBLYMAN RA: Thank you.
14 CHAIRWOMAN KRUEGER: Thank you. Thank
15 you for being here tonight.
16 MR. HANSE: Thank you very much.
17 CHAIRWOMAN KRUEGER: Have a good
18 evening.
19 Next we have the Primary Care
20 Development Corporation, Mary Ford. And
21 getting up on deck, next will be the American
22 Cancer Society and then the New York State
23 Vapor Association.
24 Good evening.

1 MS. FORD: Good evening. Thank you
2 for the opportunity to testify before the
3 committee today. I'm Mary Ford. I'm the
4 director of evaluation and analytics with the
5 Primary Care Development Corporation, or
6 PCDC. We are a New York-based nonprofit
7 organization and a U.S. Treasury-certified
8 community development financial institution
9 dedicated to building excellence and equity
10 in primary care.
11 Over the last 27 years, PCDC has
12 worked with over 950 healthcare sites in the
13 Empire State, including seven DSRIP
14 performing provider systems in all corners of
15 the state. And thanks in part to the
16 New York State Legislature, we've financed
17 and enhanced healthcare facilities and
18 practices in the large majority of the State
19 Senate districts and Assembly districts, all
20 in order to improve the delivery of primary
21 care and other vital health services for
22 millions of New Yorkers.
23 The Executive Budget that we're
24 responding to calls for the formation of a

1 new Medicaid Redesign Team tasked with an
2 ambitious April 1st deadline to identify
3 $2.5 billion in savings. While we're
4 heartened by the budget's directive that the
5 gap-closing savings will be achieved with
6 zero impact to beneficiaries, we are deeply
7 concerned that the cuts that will be made
8 will compromise New York's primary care
9 safety net.
10 As you've all heard before, overall
11 less than 10 percent of DSRIP funding went to
12 primary care, behavioral health and
13 community-based social services combined,
14 even though these are the organizations that
15 provide direct services to patients and have
16 the greatest ability to provide these safety
17 net interventions.
18 We realize that many delivery system
19 reform efforts are underway, but all of these
20 initiatives rely very heavily on primary care
21 to deliver better health outcomes and to
22 lower costs, but they do not provide the full
23 and necessary support to ensure success.
24 There's been drastic underinvestment in

1 primary care, which drives providers to chase
2 after every dollar rather than focusing on
3 the whole person and patient-centered care.
4 We can't cut our way out of the
5 Medicaid deficit, especially not by cutting
6 primary care systems and community-based
7 health providers. Rather, we must invest
8 deeply in primary care to see both the health
9 improvements and fiscal stability that
10 New Yorkers deserve.
11 PCDC believes that New York should be
12 a national leader in its commitment to
13 funding a strong primary care system.
14 However, we currently don't even know how
15 much of New York State's budget we actually
16 spend on primary care costs of both public
17 and private payers. There are other states,
18 I think about 10 to date, that are measuring
19 primary care spend across payers, all with
20 the goal of then increasing the proportion of
21 the healthcare dollar that goes to primary
22 care.
23 We urge the Legislature to measure and
24 increase the proportion of New York State

1 healthcare dollars that are spent on primary
2 care.
3 We also support the maintenance of the
4 Patient-Centered Medical Home program. For
5 many years New York State Medicaid has
6 emphasized the PCMH model as a mechanism to
7 support integrated and value-based care.
8 Primary care provider organizations have made
9 extensive commitments to the PCMH practice
10 transformation journey, knowing and believing
11 that there would be incentive payments from
12 the Medicaid program to help support the
13 continued stability of this program. And
14 numerous studies show that the longer a
15 practice is engaged with PCMH, the overall
16 impact of lowered costs and increased
17 outcomes increase.
18 So there's already been cuts to the
19 per-member per-month payments for PCMH, and
20 so we urge that funding and investments do
21 not be cut further, and continue to work
22 closely with the Health Department to ensure
23 that Medicaid reimbursement and waiver funds
24 are spent as close to the primary care system

1 as possible.
2 In addition, the Governor's budget
3 calls for a 3 percent surcharge on all
4 Certificate of Need applications for capital
5 projects. PCDC believes this tax should not
6 apply to community-based providers and small
7 projects, as this presents one more financial
8 barrier to important healthcare facility
9 expansions in low-income communities.
10 Specifically, small community-based providers
11 can't afford this additional tax. They
12 operate with very thin margins and face
13 potential cutbacks in funding.
14 And then, lastly, we say again we
15 thank the Legislature for your continued
16 support of PCDC, and we hope that you will do
17 so again in the upcoming budget year. Last
18 year the allocation to PCDC allowed us to
19 carry out our critical mission in evaluating
20 primary care access across New York State and
21 strengthening the primary care sector by
22 promoting strategies for interdisciplinary
23 care.
24 So again, we thank you for your time

1 and consideration of PCDC's recommendations.
2 CHAIRWOMAN KRUEGER: Thank you.
3 Senate? Well, I actually have one question.
4 So for years you've been up here
5 talking about how DSRIP didn't really go to
6 the right places. And I've been asking
7 during the day if anyone else saw something
8 in the budget leading them to believe that
9 we're going to sweep DSRIP funds, even from
10 previous years.
11 Is your group aware of this in any
12 way?
13 MS. FORD: To sweep? I'm not --
14 CHAIRWOMAN KRUEGER: To sweep the --
15 the feds still owe us money for the last
16 three years. People were spending it in
17 hopes they'd actually get it, but you're not
18 going to get it because there's -- the
19 Governor is going to sweep it if it comes in.
20 Have you been told this?
21 MS. FORD: I have not been told this.
22 I'm not sure if anyone at our organization
23 has more information. But I'd be happy to
24 get back to you with anything that we're

1 aware of.

2 CHAIRWOMAN KRUEGER: Just keep
3 digging. Because there's something in me
4 saying, be worried. And you're the people
5 who do worry. Okay? Thank you.

6 MS. FORD: Thank you.

7 CHAIRWOMAN KRUEGER: All right, thank
8 you very much.

9 American Cancer Society Cancer Action
10 Network, Julie Hart, senior director.

11 MS. HART: Hi, everybody.

12 CHAIRWOMAN KRUEGER: Then Vaping,
13 followed by Alzheimer's.

14 MS. HART: Good evening. I'm Julie
15 Hart. I'm the director of government
16 relations for the American Cancer Society
17 Cancer Action Network.

18 So you have a copy of my testimony in
19 front of you. And, you know, we all know
20 somebody that's been impacted by cancer, and
21 you can see on the first page of my testimony
22 there's charts that outline, all right, what
23 is the cancer burden like in New York State.

24 So we estimate for 2020 there will be

1 approximately 117,000 new cancers diagnosed,
2 and a little under 35,000 people will lose
3 their lives to cancer. We've also broken
4 this down by type as well, so breast cancer
5 remains the most commonly diagnosed cancer,
6 and right now lung cancer remains the
7 deadliest cancer in New York State.
8 We do know that screening is a
9 critical component to reduce these numbers.
10 We are fortunate that the state does have a
11 strong Cancer Services Program, which does
12 screen for breast, cervical and colorectal
13 cancer. Now, unfortunately, that program was
14 substantially cut a few years back by
15 $5.4 million. You can see, if you look on
16 page 2, the number of services that have been
17 provided in the past year, and it includes
18 over 40,000 breast cancer screening services.
19 So there still is a huge need for this
20 program. Even though we've reduced the
21 number of uninsured, we still have a number
22 of men and women that rely on the Cancer
23 Services Program for a life-saving cancer
24 screening.

1 In addition to that, the department
2 also funds what's referred to as the Cancer
3 Prevention and Action Program. And this
4 program is funded, but unfortunately only in
5 12 counties right now. One of their charges
6 is HPV vaccine education. The HPV vaccine,
7 make no doubt about it, it is a cancer
8 vaccine. It can help prevent six types of
9 cancers. If the HPV vaccine were
10 administered to all, we could virtually
11 eliminate cervical cancer, that's how
12 important it is.
13 The good news, if you look -- I
14 believe it's on page 3 -- you can see the
15 completion rates for New York State, and
16 those numbers have increased. So we have now
17 about 57 percent of kids in the target age
18 have been vaccinated and have completed their
19 vaccination, I should say. It's a two-dose
20 series as well.
21 But unfortunately, again, this program
22 is only right now offered in 12 different
23 counties, so there's a huge gap there.
24 Now, when it comes to tobacco control,

1 you'll see on pages 4 and 5 we have breakdown
2 of youth tobacco use, some trends that we're
3 seeing over the past few years, and also who
4 is still smoking in New York State is on
5 page 5.
6 So while there's some encouraging
7 steps in the Governor's budget, there's a lot
8 of different proposals there, we think it's
9 really important that we make sure that we
10 focus on the most effective interventions.
11 That has to include money for the state's
12 tobacco control program, given the huge surge
13 of kids that we have seen that are now
14 addicted to nicotine. E-cigarettes are a
15 tobacco product. FDA regulates them as a
16 tobacco product. We need to invest more in
17 the tobacco control program to help those
18 kids.
19 Now, the Governor's proposal does
20 include a restriction for flavored tobacco
21 products -- excuse me, for flavored
22 e-cigarettes. We think it's critical that
23 that applies to all products. We don't want
24 to drive kids from e-cigarettes to other

1 flavored tobacco products. So it has to be
2 comprehensive.
3 It also needs to include menthol
4 cigarettes. Most people don't realize that
5 youth smokers are the most likely to use
6 menthol cigarettes. That's because menthol,
7 similar to when you have a cough drop, where
8 it's soothing, that's what menthol does in
9 tobacco. It sooths and it suppresses coughs,
10 so it's designed as a starter product, and it
11 is most frequently used by kids.
12 Now, in addition, you may hear claims
13 from the opposition saying, You know what,
14 adults need flavored vaping to quit. But the
15 numbers don't show that. Thirty-seven
16 percent of New York State high school kids
17 are using e-cigarettes. For adults, that
18 number is actually below 6 percent, and half
19 of them are still smoking. So it means
20 they're not quitting, they're dual users.
21 And then lastly, I just want to touch
22 on one of the recommendations we have in here
23 is a cigarette tax increase. We've heard a
24 lot of talk about the need for revenue, which

1 certainly there is a need for revenue. If
2 you raised the cigarette tax by $1 -- which
3 is justified because we have not had a
4 cigarette tax increase in 10 years. Our tax
5 is stale. We desperately need it -- it would
6 generate $30.4 million. And it's estimated
7 that over 61,000 New Yorkers would quit. So
8 there's a huge public health benefit.
9 So strongly encourage you to take a
10 look, and there's a summary on the back page
11 of all our recommendations.
12 Just in the nick of time.
13 CHAIRWOMAN KRUEGER: Assembly?
14 CHAIRWOMAN WEINSTEIN: Assemblyman Ra.
15 ASSEMBLYMAN RA: Thank you.
16 I just had a couple of quick
17 questions. With regard to the e-cigarettes
18 and other youth smoking, I know that, you
19 know, for years you guys advocated for and
20 now were successful with Tobacco 21, which I
21 supported.
22 And, you know, I've been reading some
23 data with regard to kids oftentimes getting
24 those products from -- you know, maybe they

1 have a 19-year-old friend or somebody's older
2 brother or something like that. You know,
3 somebody within their social circle. And
4 that a lot of them would get those types of
5 products.
6 So what kind of impact do you think
7 Tobacco 21 is having and will have on maybe
8 cutting into some of that teen smoking?
9 MS. HART: When we looked at
10 Tobacco 21 evidence, it was estimated that it
11 would reduce youth smoking by 12 percent.
12 Now, where it's going to have the biggest
13 impact is those that haven't already started
14 on a tobacco product. So it will take some
15 years for that 12 percent reduction to
16 actually come to fruition.
17 ASSEMBLYMAN RA: And then the other
18 thing is the -- I mean, every year I look at
19 these and I was looking at this data again in
20 the fall. The fact that we talk about these
21 issues and have -- we are so low below where
22 the CDC says we should be in terms of our
23 spending --
24 MS. HART: In terms of funding, yes.

1 The CDC recommendation is 203 million, and
2 we're at 39 million.
3 ASSEMBLYMAN RA: I mean, I would
4 assume that could have a great impact too on,
5 you know, counteracting advertising that's
6 targeted towards young people, educating them
7 about the impacts of using these products. I
8 think getting up to that or somewhere in the
9 vicinity -- and, you know, I applaud you for
10 pushing for a multiyear effort to get us
11 there.
12 MS. HART: Absolutely. It's critical
13 that we don't replace funding with policy
14 pieces. They can supplement, but we have to
15 increase funding.
16 ASSEMBLYMAN RA: Thank you.
17 MS. HART: Thank you.
18 CHAIRWOMAN WEINSTEIN: Assemblyman
19 Byrne.
20 ASSEMBLYMAN BYRNE: Thank you.
21 Hey, Julie. I just wanted to -- one
22 of the counterarguments that we hear a lot is
23 about the black market. So if we're going to
24 consider a prohibition on flavored products,

1 the thought is people will still be able to
2 access them from other states or potentially
3 from the black market. And with people
4 accessing black market vape products, we've
5 seen a lot of concerns with that.
6 How would you respond to those
7 counterarguments and -- as far as prohibition
8 on the flavors?
9 MS. HART: Certainly we would like to
10 see that addressed as well, and we are in
11 agreement. We do know Massachusetts just
12 implemented a full ban -- it includes all
13 tobacco products, including menthol
14 cigarettes. So certainly we also need to
15 look at online sales as well.
16 ASSEMBLYMAN BYRNE: Thank you.
17 CHAIRWOMAN KRUEGER: Thank you very
18 much. Appreciate it.
19 Next we have the New York State Vapor
20 Association. Then Alzheimer's Association,
21 then Housing Works.
22 MS. BABAIAN: Hi. Thank you for
23 having us here today. My name is Spike
24 Babaian. I am the technical analysis

1 director for New York State Vapor
2 Association. We represent 700 mom-and-pop
3 vape shops, small businesses around the State
4 of New York. We do not take funding from Big
5 Tobacco, Big Pharma, or any other large
6 corporations.
7 The last couple of months we've heard
8 a lot about illnesses and deaths. And the
9 FDA, the CDC and the New York State
10 Department of Health -- actually, first the
11 New York State Department of Health --
12 confirmed that tainted cannabis cartridges
13 causes the lung illness and death that
14 happened last year. Yet we're continuing to
15 push a flavor ban that has nothing to do with
16 youths getting sick or dying, but does have
17 to do with reducing youth use.
18 We understand that. But a flavor ban
19 will eliminate 95 percent of e-cigarettes
20 currently sold. It eliminates a
21 billion-dollar industry, decimates hundreds
22 of small businesses, costs thousands of jobs,
23 adds flavored nicotine to an untaxed
24 underground market where no one checks

1 I.D. -- on the street, no one checks
2 children's I.D.
3 It also has no regulation, which by
4 the way is how all of those people got sick
5 last year, because there was no regulation of
6 cannabis, because it was illegal. If we make
7 the product illegal, there's no regulation.
8 National data shows 77.7 percent of
9 youth are not using e-cigarettes for the
10 flavor. This is 2019 National Youth Tobacco
11 Survey data. I'm sure that you have heard a
12 high percentage of youth are using it for the
13 flavor, but 77 percent are not using it for
14 the flavor. So we're not sure where the
15 other data may be coming from. It looks like
16 2013 data, which was before the high-nicotine
17 pod systems came out.
18 Hundreds of studies, esteemed
19 researchers, nicotine and tobacco doctors,
20 harm reduction experts with decades of
21 experience, the CDC, the Surgeon General and
22 the FDA all agree vapor products have the
23 potential to reduce smoking and to reduce
24 death and disease from smoking. Yet the

1 New York State Budget says that banning
2 e-cigarettes is going to prevent death and
3 disease and save New York billions of dollars
4 in Medicaid costs.
5 If we take away the product that keeps
6 people from smoking, how is that going to
7 reduce Medicaid costs? If they go back to
8 smoking, that increases Medicaid costs -- not
9 by a little bit, by a lot.
10 A new study that came out on Monday
11 provides us with a better understanding of
12 the youth vaping patterns. It's critical for
13 us to understand this when making policies.
14 Dr. David Abrams from NYU School of
15 Global Public Health said, "Reacting too
16 quickly to reports of youth vaping without
17 considering the full context could do more
18 harm than good. We need to avoid
19 prohibitionist regulations like banning
20 e-cigarettes while leaving the much more
21 deadly cigarettes and cigars in corners
22 stores. Instead, we should consider strong
23 enforcement of age 21 sales restrictions.
24 Prohibition creates a black market for vaping

1 products or inadvertently pushes individuals
2 back to smoking."
3 Cheryl?
4 MS. RICHTER: So hi, I'm Cheryl
5 Richter, I'm the executive director.
6 The unintended consequences of a
7 flavor ban means a billion-dollar market will
8 immediately go underground. Consumer choices
9 after a flavor ban are to buy it on the
10 street with no FDA regulation, no ISO lab
11 standards, no IDing, no licensing, no taxes.
12 Or they could buy it online and skirt the
13 tax. Or they could make it themselves, which
14 is easy to do and easy to get very wrong. Or
15 they can return to smoking.
16 Not to mention the severe consequences
17 to New York -- thousands on unemployment
18 payments, hundreds of millions in taxes lost,
19 billions in increased costs to Medicaid when
20 people return to smoking.
21 There are numerous state and federal
22 laws that just went into effect that will
23 help curb youth vaping. A New York Supreme
24 Court judge cautioned the Legislature to give

1 these laws time to be effective.
2 As of next week, FDA removes from the
3 market the small high-nicotine flavored
4 e-cigarettes, other than tobacco and menthol.
5 They are banning the devices that they have
6 determined, by looking at the data, to be the
7 preferred product of youth -- the ones that
8 looks like the thumb drives, for the most
9 part.
10 We've repeatedly recommended
11 regulations to curb youth use, including
12 employee training, I.D. scanners, marketing,
13 display and packaging restrictions, and
14 online age verification. We suggest a
15 compromise, a liquor store model that allows
16 tobacco and menthol flavors where deadly
17 cigarettes are sold, but restricts other
18 flavors to age-restricted environments.
19 MS. BABAIAN: We had a bunch of
20 comments on the budget, but as we're out of
21 time -- we had specific comments on parts of
22 the budget, but they are included in our
23 testimony.
24 So if anyone has questions, we're

1 happy to answer them.
2 CHAIRWOMAN KRUEGER: Senators?
3 Assembly.
4 CHAIRWOMAN WEINSTEIN: Assemblyman
5 Garbarino.
6 ASSEMBLYMAN GARBARINO: Just one quick
7 question. I'm not in favor of the total
8 flavor ban. I think if we can have something
9 called -- we have flavored alcohol -- cherry,
10 pineapple. But one of the things that people
11 talk about is how many kids are using it.
12 Would you agree it might help the
13 industry if they got rid of certain names,
14 you know, like Unicorn Milk or all these
15 other --
16 MS. RICHTER: We agree with certain
17 marketing restrictions. And over the years,
18 where we have been trying to bring about a
19 lot of change with, you know,
20 childlike-looking things, the FDA has finally
21 started really regulating those kinds of
22 images and names and that kind of thing.
23 ASSEMBLYMAN GARBARINO: Okay. Thank
24 you.

1 CHAIRWOMAN WEINSTEIN: Assemblyman
2 Byrne.
3 ASSEMBLYMAN BYRNE: I want to thank
4 you for being here as well.
5 A similar question to the speaker who
6 just asked before. If we're going to ban
7 flavors for a vape product, a concern -- I
8 know you've already expressed in your
9 testimony that it could go underground. I'm
10 taking that as going to the growing black
11 market, where we have already seen that
12 people have had access to some of these
13 devices where they've had harmful chemicals
14 in them and it's caused fatal issues where
15 people have actually lost their lives and
16 gotten really, really ill.
17 I also wanted to just confirm
18 something, because your comments in answering
19 the question from my colleague Mr. Garbarino
20 about the marketing -- I think I showed you
21 some of the pictures in my district. There
22 is a vape shop in the hamlet of Carmel in
23 Putnam County right next to a public library,
24 and they have posters that take up the entire

1 space of the storefront window. And on those
2 posters there's a picture of -- it looks like
3 four or five 20-year-olds. So it clearly is
4 marketing to young people.
5 To me, that's like a pretty clear
6 argument not -- it's not necessarily the
7 flavors, but restrictions on things like
8 that, rolling things like that back and
9 controlling that, those are restrictions that
10 you would be in favor of?
11 MS. RICHTER: Yes.
12 MS. BABAIAN: Mm-hmm. We've
13 encouraged those, you know, year after year,
14 and somehow they don't ever seem to be -- get
15 passed.
16 ASSEMBLYMAN BYRNE: Okay, thank you.
17 CHAIRWOMAN KRUEGER: Just for the
18 record, I don't have my colleagues here
19 tonight, and I'm just too tired to have the
20 argument tonight. But I actually think we
21 should try to do everything imaginable to
22 stop young people from using these products
23 in any way. Just to go on record.
24 Now I'm going to ask you to leave.

1 Thank you very much for being here tonight.
2 MS. BABAIAN: Thank you so much for
3 your time. I just hope that people will
4 consider we can't undo this once it's done.
5 CHAIRWOMAN KRUEGER: Thank you.
6 Followed by Alzheimer's Association.
7 I would also like to make that illegal. Is
8 the Alzheimer's Association still here? No?
9 Anybody want to rep Alzheimer's tonight?
10 Okay, let's just make it illegal. Thank you.
11 Housing Works is next, followed by the
12 Sickle Cell Thalassemia Patient's Network.
13 MR. KING: Charles King, CEO of
14 Housing Works, also representing some 90
15 organizations through our members of the
16 Ending the Epidemic Coalition.
17 I want you all to know I was thrilled
18 when I came in and saw how far up the list I
19 had moved after --
20 (Laughter.)
21 MR. KING: -- closing you all out the
22 last two years in a row. And I believe I'm
23 actually testifying the latest I've ever
24 testified in front of you all. So I

1 congratulate you on your endurance.
2 SENATOR RIVERA: The earliest.
3 Earliest.
4 CHAIRWOMAN KRUEGER: Earliest, you
5 meant.
6 MR. KING: I'm sorry?
7 SENATOR RIVERA: The earliest.
8 MR. KING: No, I actually -- I think
9 I've testified earlier than this before. So
10 I congratulate you on your endurance.
11 So look, this is 2020. This is the
12 year we're supposed to be ending the
13 epidemic, under the Governor's plan. And
14 we're also supposed to be launching an effort
15 to eliminate hepatitis C as well as
16 addressing the opioid epidemic.
17 But the reality is that the Governor's
18 Executive Budget doesn't rise to this
19 historic moment. And in fact, not only do
20 his proposals fall dangerously short of
21 concrete commitments to achieve these goals,
22 at the same time he is undermining the
23 Medicaid program and the overall health and
24 well-being of the most vulnerable

1 New Yorkers.
2 Now, I want to speak first to the
3 Medicaid proposed cuts and MRT process. I'm
4 not at all opposed to the MRT process. I was
5 very suspicious of it the first round, and
6 railed against the first set of things that
7 came out of it, but Housing Works submitted
8 17 proposals and 12 of them were ultimately
9 implemented. So I think the MRT process,
10 properly done, can be successful.
11 But I want to point out that the MRT
12 process in its first round last time was done
13 before the budget was passed, and the
14 Legislature had the opportunity to fully
15 consider everything that was in it. And it
16 should be done exactly that way once again.
17 I would also point out that there's
18 considerable bad faith when in the Governor's
19 Budget there are these shocking cuts to the
20 MRT-related housing investment that could put
21 more than 5,600 households homeless. And I
22 know, Senator Krueger, you referenced that
23 earlier in your questions this morning.
24 But that actually gives me an

1 opportunity to address Senator Rivera's
2 question about the cap. Absolutely, the cap
3 needs to be reconsidered. It was an
4 artifice. And I want to recall the promise
5 of the cap. The cap was an artifice that
6 contained spending. And great, it worked for
7 several years. It didn't get raised as it
8 should have been.
9 But the promise of the cap was if you
10 did savings under the cap, those savings
11 would get reinvested in social determinants
12 that would improve health outcomes and
13 further drive down the cost of healthcare.
14 And the Governor followed through on that for
15 the first two years, and then Year 3 the
16 Division of the Budget started clawing that
17 money, and they have never lived up to the
18 promise of savings under the global cap being
19 reinvested.
20 So how dare they now say we're over
21 the global cap? And how dare they cut
22 housing for people who are some of the most
23 frail New Yorkers and potentially risk making
24 them homeless?

1 I also want to stress that there's
2 another issue with this whole process. First
3 of all, last year we had -- not last year,
4 last time round, we had an innovator in the
5 person of Jason Helgerson, who was really
6 driving this process and looking for good
7 outcomes.
8 The Division of the Budget has been
9 meeting with folk in DOH and the second floor
10 every Thursday for the last several months to
11 line up exactly what is going to be put
12 before this MRT. So the fact of the matter
13 is, this isn't being driven by an innovator
14 who's looking to improve health outcomes,
15 this is being driven by the New York State
16 Budget Director, who's also already been
17 proven to be more interested in slashing
18 state expenditures in the short term, even at
19 the risk of public health.
20 Further, as was the case with the
21 first time, this process is going to be very
22 strongly influenced by the hospitals, nursing
23 home industry, and their allied unions, who
24 will have the strongest voices -- when in

1 fact transformation of those very industries
2 is what we need if we really want to
3 right-size our healthcare in New York.
4 That would mean transitioning to
5 community health services as the primary
6 focus of care, closing unnecessary beds,
7 closing failing hospitals where there are
8 alternatives for care, and elimination of
9 redundant expensive equipment and procedures
10 that drive the most profitable hospital
11 revenues.
12 So just to quickly go to the other
13 areas of the budget, because I don't want to
14 ignore them, once again we see Article VI
15 cuts, particularly imposed on New York City
16 but also imposed on other localities. This
17 funds basic public health. We can't allow
18 that to happen.
19 And we're very concerned about what's
20 going to happen with the healthcare program
21 under the MRT process. And also, once again,
22 the Governor has failed to live up to his
23 promise around overdose prevention centers.
24 And the rest is all in my testimony.

1 CHAIRWOMAN KRUEGER: Any questions?
2 Senator Rivera.
3 SENATOR RIVERA: Thank you for hanging
4 out for as long as you have, sir.
5 So I wanted to get back to talking to
6 you about what you were talking about, the
7 MRT. Specifically, you did say that you
8 railed against the first process but
9 eventually became a believer in it. And then
10 you -- at the end of the time when you were
11 talking about it just now, you did say that
12 you believed that this could be successful if
13 it's done the same way.
14 We have to acknowledge that it has not
15 been done the same way. Because again, I was
16 pointing out this morning, it is January
17 29th -- it technically still is January 29th,
18 although who knows, it might get to midnight.
19 But it's January 29th and we don't have any
20 information.
21 On January 29th of 2011, we already
22 had the MRT that had been put into place,
23 they had already -- the membership was
24 already established, there might have already

1 been meetings, there were already
2 conversations. Here we are on January 29th,
3 we don't even know who's in it.
4 So at least you can acknowledge that
5 it has not been -- that it has not been
6 carried out the same way.
7 MR. KING: I thought you were going to
8 ask if I'd been asked. I was going to say,
9 you see how far I fell on the
10 {unintelligible} list --
11 SENATOR RIVERA: Charles, see, now
12 you -- Charles, you're ruining my bit. That
13 was supposed to be the second question,
14 because everybody expected for it to be the
15 first one.
16 But anyway, answer the first
17 questions, then we'll get to that one. So do
18 you believe, as far as the process right
19 now --
20 MR. KING: No, I -- I think I was
21 trying to indicate I believe that this
22 process is already completely rigged, and
23 it's up to the Legislature to stop this
24 process and put a more sensible process in

1 place.
2 By the way, you didn't ask me, but in
3 my testimony we do support and are happy to
4 stand here and tell you that we support
5 raising taxes on the wealthy, raising
6 taxes -- putting taxes on second homes, all
7 the rest of that good stuff. It's not a lack
8 of revenue or resources, it's lack of
9 political will.
10 SENATOR RIVERA: That was going to be
11 my third one, but you answered that one.
12 And so you haven't been asked to be
13 on?
14 MR. KING: I'm sorry. I'm sorry.
15 SENATOR RIVERA: I'm going to find one
16 person, I swear. I'm going to find one
17 person. Thanks a lot, Charles.
18 Thank you, Madam Chair.
19 CHAIRWOMAN KRUEGER: Thank you. Thank
20 you very much, Charles.
21 MR. KING: Certainly.
22 CHAIRWOMAN KRUEGER: Okay. Sickle
23 Cell Thalos -- Thalasom -- oh, just say it
24 when you get up here so then I don't keep

1 embarrassing myself.
2 MR. MOULTON: Hi. It's Sickle Cell
3 Thalassemia Patient's Network.
4 CHAIRWOMAN KRUEGER: Of course. Thank
5 you. Welcome.
6 MR. MOULTON: Hi, I'm Thomas Moulton.
7 I'm a pediatric hematologist, and I have
8 treated sickle cell disease patients for
9 approximately 30 years. I am part of the
10 board of SCTPN, which is easier to say than
11 Sickle Cell Thalassemia Patient's Network.
12 And I also am kind of a de facto
13 coordinator for sickle cell groups throughout
14 the state to promote the sickle cell bill
15 that is now in its ninth or maybe even tenth
16 year that it's here and still has not been
17 passed or funded. And it is Assembly Bill
18 6493 and Senate Bill 2281.
19 New York State is the second most
20 populous state with sickle cell disease and
21 has 10 percent of the nation's sickle cell
22 disease population. The median survival of
23 severe sickle cell disease is 38 for men and
24 42 for women. However, 95 percent of

1 children will live to the age of 18. Which
2 means that 45 percent of deaths will occur in
3 a 20-year period between ages 18 and 38. Let
4 me repeat that. Forty-five percent of the
5 deaths from sickle cell disease occurs in the
6 adult years -- young adult years -- between
7 18 and 38.
8 So it was stated before that people
9 with -- from overdoses are dying because
10 funding isn't there. For 10 years, there's
11 been no funding for sickle cell disease,
12 essentially, from this Legislature and from
13 the Governor. So the Governor has just as
14 much responsibility in it.
15 It is the largest healthcare
16 disparity, as many if not most of the adult
17 sickle cell patients have no medical home and
18 really only use the ER for care. Other
19 states with fewer sickle cell disease
20 patients provide more funding for sickle cell
21 disease. California just passed 15 million,
22 15 million for five hub-and-spoke programs.
23 North Carolina has 4 million. While New York
24 State has cut funding for sickle cell disease

1 over the last 20 years by 66 percent -- a
2 66 percent cut in funding -- and only has
3 $170,000 in the budget for it.
4 And so somebody else talked about
5 racism in our budget. Hello, can you spell
6 racism? I spell it as sickle cell disease.
7 And one wonders -- so, Senator Rivera, you
8 were complaining about a possible cut of I
9 think it's $380,000 to 70 patients for cystic
10 fibrosis. There are 8,000 to 10,000 sickle
11 cell disease patients in New York State, and
12 we spend $170,000 on them.
13 So clearly -- and it's clearly shown
14 in the literature that comprehensive care for
15 sickle cell disease improves care and cuts
16 costs. In 1995, Montefiore Hospital showed
17 that day hospital saved $3 million over a
18 five-year period of time. With the increase
19 in healthcare over the last 25 years, that
20 has to have at least doubled in this.
21 However, Montefiore then cut that
22 program as soon as the federal funding for
23 that program went, despite the cry out from
24 the patients that were Montefiore-served.

1 And most -- up to 80 percent of sickle
2 cell disease patients are on Medicaid, with
3 just approximately a 3.3 percent decrease in
4 cost to New York's Medicaid, they can save up
5 to $4 million to $5 million a year.
6 So in this time where we're saying,
7 oh, Medicaid costs too much, here is a plan
8 that we've told for the last 10 years can
9 save you money, and nothing has been done
10 about it.
11 So we have been -- so the sickle cell
12 community has been blessed in terms of last
13 year we received funding from the Assembly,
14 increased funding for one year only.
15 However, the Department of Health took eight
16 months to be able to notify five programs
17 that they already had programs in it that
18 they would receive the money, and then told
19 them they needed to spend the money in three
20 months.
21 And the Senate then also provided
22 extra funding to community-based
23 organizations in June of last year. To date,
24 SCTPN has not received one dime of that

1 money, and now are told that they need to
2 spend that money by March 31st of this year.
3 So less than two months to try and spend the
4 money.
5 Try and have improvement of care when
6 money that you're allocated is not given to
7 you until two months towards the end of the
8 time for it.
9 The sickle cell bill would allocate
10 $3 million to fund eight comprehensive sickle
11 cell centers throughout the state, and one
12 coordinating center. This will allow for
13 increased access to care and improved care
14 and create statistics on sickle cell disease,
15 including costs of care, for which there are
16 no statistics on sickle cell disease done by
17 the Department of Health.
18 Thank you.
19 CHAIRWOMAN KRUEGER: Any questions?
20 We're going to follow up, because the
21 state is famous for taking eight, 10 months
22 to start funding, specifically when it comes
23 from members' items of the Legislature. But
24 they've never had it that it has to be spent

1 in two months. So we're checking and
2 following up with you --
3 MR. MOULTON: They have received
4 letters --
5 CHAIRWOMAN KRUEGER: I don't think
6 that's correct.
7 MR. MOULTON: -- stating that the
8 funding must be spent by March 31st.
9 CHAIRWOMAN KRUEGER: That has not been
10 the history.
11 MR. MOULTON: And I must thank your
12 office, because you helped SCTPN actually
13 find out who were the sponsors from the
14 Senate for it, and it helped to try and
15 figure out how to do and where the money is,
16 along with Senator Gianaris.
17 But they still could not figure out
18 how to be able to get the money, and they
19 never received a letter from the Department
20 of Health that they received the money.
21 CHAIRWOMAN KRUEGER: So we're going to
22 be following up with you.
23 MR. MOULTON: Thank you.
24 CHAIRWOMAN KRUEGER: And I cut you

1 off, Senator Rivera, I'm sorry.
2 Anyone in the Assembly?
3 Thank you for staying so late for us.
4 MR. MOULTON: I hope you'll give us
5 the $3 million to rectify it.
6 (Laughter.)
7 CHAIRWOMAN KRUEGER: Thank you.
8 Okay, now we have the Home Care
9 Association of New York State.
10 We started with a longer list, but we
11 might be down to one rep, which is fine. One
12 person in five minutes is a good match.
13 MS. LOVELACE: I promise I won't take
14 all five minutes.
15 CHAIRWOMAN KRUEGER: It's okay.
16 MS. LOVELACE: Hello, everybody.
17 Thank you for having me. I'm Alyssa
18 Lovelace. I'm the director for policy and
19 advocacy at the Home Care Association of
20 New York State. Al Cardillo wishes he could
21 be here today; he is our president. He is
22 teaching class up the street.
23 HCA represents home care agencies,
24 hospices and managed long term care plans

1 throughout the State of New York, along with
2 allied members and other associate members as
3 well, who all support the mission of those
4 home care agencies and managed long-term care
5 plans and hospices.
6 You have our written testimony. There
7 is a lot in there. And I am going to start
8 by saying that as it relates to the Medicaid
9 Redesign Team, we have asked directly if we
10 could be a participant, but we did not hear
11 anything.
12 To that end, we have explained the
13 process of MRT and how home care was part of
14 the process -- or actually not part of that
15 process -- and we would like a seat at the
16 table moving forward.
17 To that end, I just have three quick
18 points that I want to drive home that are
19 positive, that I think that home care,
20 managed long term care, we can actually be of
21 help in this year's budget.
22 The first is how to improve the
23 healthcare system through the optimization of
24 Medicare. This means having health plans and

1 providers adopt and follow guidelines that
2 optimize the use of Medicare services through
3 providers such as certified home health
4 agencies and hospices. So they should follow
5 guidelines by optimizing Medicare, by
6 ensuring that Medicare is a first payer
7 before a dual-eligible moves into a Medicaid
8 product. So essentially, Medicaid should be
9 the payer of last resort.
10 We would like to reactivate laws
11 requiring referrals to hospices, maximize new
12 potential for extended home healthcare
13 coverage provisions under the federal Jimmo
14 settlement. A lot of this is
15 Medicare-related, obviously. We are talking
16 next about 222 waivers and using the
17 flexibilities within those waivers. And that
18 would come through CMS. It is something that
19 has been done since the '70s, and so we have
20 seen them happen, they have been verified.
21 222 waivers are granted to providers in this
22 state to allow them more innovative options,
23 and this is just another path we can take
24 rather than increase Medicaid expenditures.

1 The second point is to create
2 efficiencies and strengthen cost-control
3 capabilities in managed long-term care, home
4 care, and the consumer-directed program. So
5 we suggest amending state laws and procedures
6 to allow MLTCs and home care providers better
7 capability to control utilization and costs,
8 create operational and procedural
9 efficiencies including the ability to preempt
10 avoidable visits and elimination of
11 regulatory redundancies.
12 I think that we can all agree that
13 there are many regulatory redundancies, and
14 we would like to aleve {sic} the Department
15 of Health of some of those. And I think that
16 the Home Care Association, our sister
17 organizations, we can come together and see
18 where there are redundancies within that
19 system.
20 And finally, prevent organizational
21 practices tied to higher costs. That brings
22 me to the CDPAP program and marketing
23 guidelines. And that is something that we
24 can most certainly talk offline about. It

1 was talked about earlier today when the
2 commissioner was up, and will be talked about
3 later.
4 And then finally -- and this really
5 gets to the part about home care and its
6 strengths. So the providers and their
7 workers, they know the communities inside and
8 out. They know the environmental hazards,
9 they are culturally competent, they're aware
10 of the diverse populations. These people are
11 living -- the workers are living and
12 breathing in the homes, they see the
13 communities. What preventative ideas are out
14 there that we can help keep people in their
15 homes and in their communities longer?
16 HCA last year we released a number of
17 initiatives starting with, of course -- and
18 I'm going to say it out loud -- their sepsis
19 program. There was $195 million in annual
20 fee-for-service Medicare payments for in-home
21 patients that was an attributable savings.
22 To that end, we think that we could move
23 forward budgetarily with this sepsis program.
24 Senator, you were a key factor in that

1 legislation moving, so thank you.
2 We also advanced a $20 million,
3 roughly, asthma management program. And then
4 of course there's telehealth for chronic
5 disease management, such as CHF and diabetes
6 management. And those are two diseases that
7 have a high likelihood of interactions in the
8 healthcare system.
9 So at the end of the day, the home
10 care workers, the agencies, they're in the
11 community, and we can definitely be a
12 resource to the Legislature and the Executive
13 as we move forward trying to figure out the
14 budget.
15 CHAIRWOMAN KRUEGER: Thank you.
16 Senate? Assembly? We're good.
17 MS. LOVELACE: Thank you.
18 CHAIRWOMAN KRUEGER: Thank you very
19 much for your testimony.
20 Moving on to the New York State
21 Association of Health Care Providers,
22 followed by New York Public Interest Research
23 Group, followed by a panel of Continuing Care
24 and LeadingAge.

1 MS. FEBRAIO: Good evening.
2 CHAIRWOMAN KRUEGER: Good evening.
3 MS. FEBRAIO: Thank you for having us.
4 My name is Kathy Febraio. I am the president
5 and CEO of the New York State Association of
6 Health Care Providers. This is Kevin Kerwin,
7 our VP of public policy.
8 We are a statewide association
9 representing licensed home care services
10 agencies, certified home health agencies,
11 fiscal intermediaries, and related health
12 organizations throughout New York. We are
13 the providers of the long-term care and
14 personal care services that have been
15 referred to throughout the day.
16 And first and foremost, I want to say
17 that we are very proud of the work that we do
18 and the ability for our patients to be able
19 to stay in their homes with dignity.
20 Right now our members are reeling from
21 the perfect storm of increases in direct care
22 costs, severely inadequate reimbursement
23 rates, and the lack of adequate and timely
24 contract amendments from the managed

1 long-term care organizations to cover those
2 increases in costs.
3 Now more than ever, it is important
4 for New York to invest in home care and
5 protect the viability of this industry so
6 that we can ensure that individuals with
7 disabilities, chronic illness, and elderly
8 populations to continue to have access to
9 services that allow them to remain in the
10 comfort and safety of their own homes.
11 I thank you for your in-depth
12 questioning today of the Department of Health
13 regarding the Medicaid budget and the MRT II.
14 A lot of the details that you identified are
15 the same concerns that we have. And our
16 members are worried that -- because during
17 MRT I the home care industry did not fare
18 very well, and workgroups were created after
19 the fact to mitigate issues, but the train
20 had left the station and it was too late.
21 So long-term care and personal care
22 services are the focus of MRT II, or so it
23 seems. And so the only appropriate and
24 sensible thing to do is to include our

1 organization, along with others that
2 represent these services, as full members of
3 the MRT.
4 We did put in our request to be
5 members, and we have not yet heard.
6 So providers of home care services
7 have been cut to the bone in recent years and
8 are operating on razor-thin margins. Many of
9 our members report that this is compounded by
10 holding accounts receivable from the MLTCs
11 for far too long, for hundreds of thousands
12 of dollars and more, leaving our provider
13 members facing personal financial crises and
14 needing to secure personal loans and lines of
15 credit just to make payroll. More than half
16 of our members report this situation.
17 All the while, the home care industry
18 has been faced with multiyear licensing
19 moratoria, the new prospect of the
20 Certificate of Need process as part of their
21 licensing, contract limits with managed-care
22 organizations, increases in minimum wage, and
23 most recently, a 1 percent cut to Medicaid
24 effective January 1. All the while, they're

1 preparing for the implementation of
2 electronic visit verification coming end of
3 this year. And none of these efforts improve
4 the quality of care. In fact, they distract
5 from it.
6 So much has been said about long term
7 care and personal care services today, as if
8 the home care providers are simply corralling
9 elderly and disabled individuals out on the
10 streets and providing care to these
11 individuals without assessment to be eligible
12 for Medicaid, nor evaluated for the
13 appropriate care or services.
14 And I think you uncovered, through
15 your questioning and interviewing of the DOH,
16 that that is not the process. We are here to
17 provide the services that others indicate are
18 needed.
19 So has the program grown? Yes, it
20 has. But it's not due to increased payments
21 to providers. We've got a growing senior
22 population, we had shifts of recipients into
23 the Managed Long Term Care program that have
24 both provided growth into this program.

1 Cuts are not the answer. The Medicaid
2 system needs revenue. The state should be
3 investing in and not cutting home care. The
4 alternative will be people are going to need
5 services, and there's going to be no way for
6 them to receive it.
7 So looking to the consumer directed
8 personal assistance program as an example,
9 about half of our members are fiscal
10 intermediaries. And we urge the Legislature
11 to consider the monumental changes that are
12 going on in that program and look at it as an
13 example of what may happen in Medicaid
14 overall if the $2.5 billion is cut.
15 CHAIRWOMAN KRUEGER: Thank you.
16 Any Senate questions? Any Assembly
17 questions?
18 CHAIRWOMAN WEINSTEIN: Assemblyman Ra.
19 ASSEMBLYMAN RA: Thank you.
20 Thank you for being here and for your
21 patience. And, you know, there's no question
22 that your industry has really had a lot of
23 challenges over the years. You've done what
24 has been asked of you in many ways, and still

1 it seems like there's always something else
2 coming down the pike.
3 But one of the issues I know we've
4 spoken about many times when you've had your
5 regional meetings is, you know, with the
6 minimum wage and whether the funding that
7 this Legislature approves and sees in the
8 budget then actually gets paid out to you
9 guys in a timely manner. I was wondering if
10 you could just talk a little bit about, you
11 know, where we are with that, how your
12 members are faring with that issue.
13 MS. FEBRAIO: It continues to be a
14 challenge. We of course on December 31st had
15 another wage increase, and we are still
16 hearing from our members that they're not
17 getting contract changes in a timely manner.
18 And then often when they are getting them,
19 the rate is not covering the minimum wage,
20 the hourly rate.
21 So there's no room for administrative
22 coverage of that within that cost if you're
23 not even covering the actual minimum wage in
24 direct labor costs. So it continues to be a

1 problem, along with the long time in paying
2 those claims. So they're balancing their
3 books as best they can, but it is becoming
4 more and more of a challenge.
5 ASSEMBLYMAN RA: Thank you.
6 CHAIRWOMAN KRUEGER: Thank you very
7 much.
8 MS. FEBRAIO: Thank you.
9 CHAIRWOMAN KRUEGER: Have a good
10 evening.
11 Our next testifier, New York Public
12 Interest Research Group.
13 Good evening.
14 MR. HORNER: Good evening.
15 CHAIRWOMAN KRUEGER: You've got five
16 minutes. Don't try to read it.
17 (Laughter.)
18 MR. HORNER: We promise not to.
19 Good evening, my name is Blair Horner.
20 I'm director of NYPIRG. With me today is
21 Robert Zentgraf, one of NYPIRG's policy
22 associates.
23 You have our written testimony, and we
24 will use our five minutes to focus on some

1 key topics. First, healthcare costs.
2 As you know, the big debate in dealing
3 with the state's budget deficit is the cost
4 of healthcare, since it constitutes a big
5 portion of the shortfall. As part of solving
6 that problem, we urge you to consider how to
7 improve the quality of healthcare in the
8 state.
9 Research shows that poor-quality care
10 is more expensive than high-quality. Studies
11 published since the 1990s have shown that
12 hundreds of thousands of Americans are
13 injured or killed each year due to
14 substandard hospital care. According to a
15 2008 analysis, medical mistakes add nearly
16 $20 billion to the nation's healthcare costs.
17 And if such mistakes were spread evenly
18 across the nation, New York would lose
19 roughly $1 billion annually to substandard
20 care.
21 But substandard care is not spread
22 evenly. According to federal government
23 data, New York hospital care ranks among the
24 nation's worst. That's right. And our

1 review of the data found that poor-quality
2 rankings apply to all regions of the state.
3 We've heard a lot about the need to
4 curb costs, which if done incorrectly can
5 merely reduce access to necessary care or
6 weaken health quality efforts. We urge you
7 to demand that improved healthcare quality is
8 part of any Medicaid redesign effort.
9 Second issue, antibiotics. The rise
10 of antibiotic-resistant super bugs is a
11 worldwide crisis. We're now entering a
12 post-antibiotics era in which the smallest
13 infections, like a UTI, can lead to serious
14 illness or even death.
15 If nothing changes, experts predict by
16 the middle of this century, more people will
17 die from antibiotic-resistant infections than
18 die of cancer.
19 Two-thirds of all human-important
20 antibiotics are used on farm animals. The
21 CDC says 20 percent of all antibiotic-
22 resistant infections develop on farms.
23 Twenty percent come from farms. No one
24 disagrees that antibiotics should be used on

1 sick animals or those exposed to sick
2 animals, but dousing healthy animals with
3 antibiotics because they might get sick helps
4 breed resistant microbes.
5 So we urge you to add restrictions on
6 the use of antibiotics in farm settings to
7 the Governor's proposed efforts in this area.
8 Robert?
9 MR. ZENTGRAF: The Governor rightly
10 proposes to restrict flavored vaping
11 products. The vaping and tobacco industries
12 know quite well why they add flavoring to
13 their deadly products: It makes it easier
14 for new users to get started, and the vast
15 majority of these new users are teenagers.
16 There's a wealth of documentation that
17 the tobacco industry knows that its
18 replacement smokers are minors and that
19 sweet-flavored tobacco products make it
20 easier for kids to start using. That is why
21 the FDA banned most flavored cigarettes. But
22 other products -- cigarillos, cigars and
23 chewing tobacco -- are still allowed to be
24 flavored, and menthol cigarettes are still

1 allowed to be sold.
2 Tobacco use, including electronic
3 cigarettes, offers no useful contribution to
4 society. These are devices to addict,
5 devices to ruin user's health, and devices
6 that can lead to an early, painful death.
7 We urge you to expand the Governor's
8 ban on flavored vapes to all tobacco products
9 as well.
10 MR. HORNER: And as you'll see in our
11 testimony, it details how the state has
12 dramatically reduced its funding of tobacco
13 control programs by more than 50 percent in
14 the last 10 years. And we urge that more
15 money should be included. The money is
16 there. The state receives billions of
17 dollars each year in money from tobacco taxes
18 and the master settlement group. Use it to
19 enhance the state's pro-health efforts.
20 The Governor's budget also proposes to
21 expand the Physician Profile Program. The
22 critical failure of that program is that no
23 one knows that it exists. There must be
24 notification at all medical settings, on all

1 websites and social media platforms, that
2 such profiles exist. And if you want to look
3 at it, it's NYdoctorprofile.com, provided by
4 the Health Department, where you can get
5 background information on doctors.
6 As patients choose their doctor, they
7 must have access to public information that
8 would help them to make a decision that
9 directly affects their health. The Health
10 Department also offers a web-based tool to
11 compare drug prices in pharmacies, and
12 there's supposed to be a sign at every
13 counter in every pharmacy telling you where
14 it is. Have you ever seen one? Not the
15 retail drug prices available, that's a
16 different law.
17 The State Education Department should
18 enforce the law.
19 Thank you for this opportunity to
20 testify.
21 CHAIRWOMAN KRUEGER: All right. Any
22 questions?
23 CHAIRWOMAN WEINSTEIN: Assemblyman
24 Byrne.

1 ASSEMBLYMAN BYRNE: Sorry, I can't
2 help myself. I may be wrong, but maybe you
3 can -- a test of my memory here. And I'm
4 hoping you can help maybe explain or
5 reconcile this. Did NYPIRG express concerns
6 about Tobacco 21 last year?
7 MR. HORNER: That's right. We opposed
8 it.
9 ASSEMBLYMAN BYRNE: So how do we
10 reconcile that NYPIRG was opposing raising
11 the age to 21, and by all accounts that
12 I've -- at least in my county, enforcement
13 has been going pretty well -- but now they're
14 taking the position to ban flavored vapes?
15 MR. HORNER: Well, we've been involved
16 in tobacco control issues for over 30 years.
17 We've supported every initiative that is
18 backed by the evidence that would work to
19 curtail smoking and make access harder for
20 minors.
21 The average age for beginning smokers
22 in New York is 13. Raising it to 21 isn't
23 going to make any difference. And so
24 unless -- if the intent of public policy is

1 to discriminate against 18-, 19- and
2 20-year-olds, you achieved it. If the goal
3 is to reduce access for minors, it won't
4 work. And that's been the experience in
5 New York City.
6 ASSEMBLYMAN BYRNE: Thank you.
7 MR. HORNER: But you should ban
8 flavored tobacco products and vapes. Because
9 that's how you get started, that's how you
10 get hooked, and that makes it easier for kids
11 to get to do it. And that's why they exist.
12 The tobacco documents will tell you that.
13 It's a plan, they know what they're doing.
14 They're bad people.
15 CHAIRWOMAN KRUEGER: Thank you very
16 much for your extensive testimony that we
17 only gave a little bit of attention to
18 tonight.
19 (Laughter.)
20 CHAIRWOMAN KRUEGER: We'll talk to you
21 more.
22 All right, sorry. You know, Liz gets
23 a little tired. Continuing Care Leadership
24 Coalition, along with LeadingAge.

1 MR. AMRHEIN: Good evening. My name
2 is Scott Amrhein. I'm the president of the
3 Continuing Care Leadership Coalition, and I'm
4 delighted to be here tonight with my
5 colleague Karen Lipson from LeadingAge.
6 We know we have limited time, so I
7 will submit my formal comments for the record
8 and just hit on a couple of key points. And
9 in fact there's one sort of singular point in
10 my written testimony that I want to focus on.
11 And we all know that we have a crisis.
12 We know there's a $2.5 billion gap, and we're
13 all here to figure out how to fill it. But
14 even before that gap materialized, we had a
15 crisis brewing and manifesting in New York
16 State in terms of losing high-quality
17 not-for-profit long-term-care providers.
18 And that was really brought to light
19 by the Attorney General's office, through his
20 Charities Bureau. They issued a report in
21 late 2018 in which they really flagged this
22 as an issue, sounding an alarm over the fact
23 that these high-quality community-based
24 not-for-profit providers are closing or

1 converting. And they're not being, you know,
2 bought by other not-for-profit providers.
3 They're either out of business or it's
4 another type of sponsorship.
5 And what they noted is that we're
6 losing, on an annual basis in the last few
7 years, 5 percent of our entire not-for-profit
8 nursing home stock. So to put numbers behind
9 that, in 2011, during the last MRT, we had
10 252 not-for-profit nursing homes. By 2017,
11 we had only 207, which is a loss of 45 homes
12 over just a six-year period. And that's a
13 real, you know, tragedy for 45 communities
14 where those homes were providing outstanding
15 care.
16 We're also seeing issues with home
17 care, a lot of challenges there. We're
18 seeing some extraordinary facilities being
19 forced to scale back. And I just want to
20 reflect -- you know, Senator Jackson is no
21 longer here, but he really flagged the issue
22 in Manhattan, where I live. In Washington
23 Heights there's a facility that's been in
24 that community for 150 years, and the people

1 in that community are duly frightened that
2 that facility may have issues going on if we
3 don't change something. And just last night
4 Community Board 7 had a forum because they're
5 concerned about the other places in their
6 district, how are they going to go forward.
7 So I just want to say, you know, we
8 have pages of recommendations that we leave
9 to you to read. But if I can leave one
10 message, it's that a dual goal of this MRT
11 process, besides finding a way to close the
12 gap, really needs to be to establish that
13 there should be never be an instance in
14 New York State going forward where an
15 effectively run, high-quality provider of
16 long-term-care services will be forced to
17 sell or close in the future because of
18 shortfalls in reimbursement or budget savings
19 actions.
20 Thank you.
21 CHAIRWOMAN KRUEGER: Hi.
22 MS. LIPSON: I'm not sure this is on.
23 (Off the record.)
24 MS. LIPSON: My name is Karen Lipson.

1 I'm an executive vice president with
2 LeadingAge New York. Thank you for the
3 opportunity to testify here today.
4 LeadingAge New York is an association
5 of not-for-profit and public long-term and
6 post-acute care providers across the
7 continuum of care. Our members include
8 affordable senior housing, home care, nursing
9 homes, assisted living, hospice and
10 provider-sponsored managed long term care
11 plans.
12 I want to second everything Scott said
13 and support his remarks, but I also want to
14 speak to some broader long-term-care themes.
15 As several people have recognized here
16 today, demographic change is upon us. Our
17 population is aging, and our baby boomers are
18 in their seventies, and 70 percent of people
19 over the age of 65 are going to need
20 long-term care. So we are in a demographic
21 crisis.
22 What people have not recognized today
23 is that at the same time that our adult
24 population is rising, our working age adult

1 population is going down. And so that is why
2 we're hearing a lot about workforce
3 shortages. And in the long-term-care sector,
4 we are experiencing extraordinary workforce
5 shortages across the state -- not just
6 upstate, not just in rural areas. Our
7 members cannot fill open positions at all
8 levels.
9 So we need a proactive plan to address
10 demographic change. There's an impressive
11 and coherent plan in the budget to address
12 climate change, but I have not been able to
13 find anything in the budget to address
14 demographic change. In fact, instead of
15 preparing for demographic change, the
16 long-term-care sector has experienced deep
17 Medicaid cuts over the past two years. And
18 if you look at the bar graph in your
19 testimony, those red bars that are longer
20 than any other bar show the deep cuts that
21 the long-term-care system has borne over the
22 past two years.
23 Not only have we borne the brunt of
24 Medicaid cuts, we've been overlooked by

1 healthcare investments, investments through
2 DSRIP and investments through the Healthcare
3 Facility Transformation Grants. So
4 long-term-care providers have received only a
5 small sliver of that funding.
6 These cuts and this lack of
7 investment, as Scott pointed out, is
8 destabilizing. Our providers' margins are
9 thin to negative, and providers are closing
10 their doors.
11 So we ask you to look hard at that
12 $5 billion cut, because it is a $5 billion
13 cut, not a $2.5 billion cut when you gross it
14 up, including the federal funds. Taking
15 $5 billion out of the healthcare delivery
16 system in New York State is not sustainable,
17 and cuts cannot be focused on long-term care
18 year over year and expect long-term care
19 providers to be able to serve our
20 grandparents, our parents and ourselves.
21 So we ask you to reduce the size of
22 that cut. There must be revenues or savings
23 elsewhere in the budget that can help to fill
24 that gap.

1 We also have a five-point plan to
2 strengthen the long-term-care delivery system
3 and to build the workforce by driving
4 efficiencies and supporting care in the most
5 appropriate settings.
6 Point one is workforce, investing in
7 workforce and alleviating some regulatory
8 barriers to developing our workforce. And
9 there's a series of recommendations on that
10 green graphic that you have in your packet.
11 Supporting the delivery of services in the
12 most appropriate setting, including
13 lower-cost settings like adult care
14 facilities and senior housing, affordable
15 senior housing with services. Investing in
16 infrastructure, technology, specialized
17 services to address the needs of an
18 increasingly medically complex population in
19 nursing homes. Supporting regulatory reforms
20 that eliminate unnecessary fees, including
21 that CON fee, which is going to have a very
22 significant impact on nursing homes that need
23 to upgrade their physical plants. And
24 supporting long-term-care provider-sponsored

1 managed care programs like PACE programs and
2 Medicaid Advantage Plus programs that
3 integrate the Medicare benefits and funding
4 with the Medicaid benefits and funding to
5 provide a holistic approach to delivering
6 care.
7 We believe these five steps will put
8 us on a stronger foot to address the needs of
9 our aging population.
10 Thank you for the opportunity to
11 testify, and I'll take any questions.
12 CHAIRWOMAN KRUEGER: Thank you.
13 Questions? Questions? Then thank you
14 both very much for sticking it out with us.
15 MR. AMRHEIN: Thank you.
16 MS. LIPSON: Thank you.
17 ASSEMBLYMAN CAHILL: Thank you.
18 CHAIRWOMAN KRUEGER: All right, the
19 Associated Medical Schools of New York had to
20 leave and go home.
21 Does the New York State Area Health
22 Education System have a rep here?
23 UNIDENTIFIED SPEAKER: They do, but
24 the three individuals who are listed here

1 could not be here for reasons of illness and
2 a death in the family.
3 CHAIRWOMAN KRUEGER: I'm sorry. But
4 are you ready to testify for them?
5 UNIDENTIFIED SPEAKER: Well, you have
6 our testimony. We don't want to keep you
7 late. But we have been proposed to have our
8 system more or less eliminated in the
9 State Budget --
10 CHAIRWOMAN WEINSTEIN: If you're going
11 to talk, then you've got to come --
12 CHAIRWOMAN KRUEGER: Just come say
13 that in the mic.
14 Hi. We couldn't really hear you from
15 up there.
16 MR. WINGATE: I apologize. And I
17 didn't intend -- I'm not here with a
18 statement, and I did not intend to speak this
19 evening.
20 CHAIRWOMAN KRUEGER: That's okay.
21 That's fine.
22 MR. WINGATE: I'm sorry it's so late.
23 My name is Rob Wingate. I'm the executive
24 director of the Catskill Hudson Area Health

1 Education Center, and we are one of nine
2 healthcare workforce organizations in
3 New York State that are part of the New York
4 State Area Health Education Center system.
5 So we have partnerships with many
6 universities and schools and health provider
7 systems, focused on trying to increase the
8 quantity and improve the quality of the
9 health workforce to meet the needs of
10 underserved populations in the state.
11 So we are part of a line item in the
12 State Budget. The Governor's proposal
13 recommends the elimination of that line item,
14 which would also have the effect of
15 eliminating our capacity to leverage a
16 federal match on our line item.
17 So we operate out of the University of
18 Buffalo as a state coordinating unit, and we
19 serve every county and every borough in
20 New York City.
21 So I'd be happy to take questions if
22 you have them, but you do have the testimony
23 in front of you.
24 CHAIRWOMAN KRUEGER: Thank you.

1 Any questions? We appreciate you
2 coming and repping for the rest of your
3 group, and we will review the testimony that
4 was submitted. And thank you for being here
5 tonight.
6 MR. WINGATE: Thank you. Appreciate
7 your time very much.
8 CHAIRWOMAN KRUEGER: Thank you.
9 MR. WINGATE: Good night.
10 CHAIRWOMAN KRUEGER: All right. Next,
11 Consumer Directed Personal Assistance
12 Association of New York State. Hello, Bryan,
13 I knew you were here somewhere. Bryan
14 O'Malley, executive director.
15 Good evening.
16 MR. O'MALLEY: Good evening. Thanks
17 for being here for so long. My name is Bryan
18 O'Malley. I'm executive director of the
19 Consumer Directed Personal Assistance
20 Association.
21 As you know, last year's budget cut
22 $150 million from CDPA. It was argued this
23 cut would not harm services or wages.
24 However, when these rates were implemented --

1 thankfully for only six weeks, due to a
2 successful lawsuit -- our fears came true.
3 FIs were forced to lower wages to minimum
4 wage and eliminate the ability of consumers'
5 workers to work overtime. PAs quit, those
6 who didn't lost wages, consumers went without
7 services. I spoke to one man who lost his
8 home.
9 When some plans implemented these
10 cuts, they used it as an opportunity to reap
11 windfalls. They cut direct care payments
12 below cost even at minimum wage. If they
13 would negotiate, they only negotiated on
14 administrative rates, saying the direct care
15 component was take it or leave it.
16 A new rate structure based on both a
17 lack of programmatic understanding and data
18 led to a preordained outcome where agencies
19 were forced to cut wages for workers and
20 consumers then went without needed services
21 as a result.
22 Now, as the Governor convenes a new
23 MRT, he says he will cut without negatively
24 impacting Medicaid recipients or services.

1 To those of us who heard this argument last
2 year, we ask he take a step to show he means
3 it. Withdraw the draft regulations on the
4 new reimbursement for CDPA. The negative
5 impact these rates have on both wages and
6 benefits was apparent. To continue to move
7 forward with them would call into question
8 the desire to avoid cuts that impact current
9 beneficiaries or workers.
10 Frankly, a large driver of the growth
11 in CDPA has been the efforts to get every
12 person covered. With much of the coverage
13 growth occurring among seniors, it is
14 predictable that usage rates are growing,
15 particularly in long-term care. And this
16 growth -- contrary to what you heard today,
17 this growth is not unreasonable, even if the
18 statistics presented are.
19 The fact is 13 percent of the managed
20 long term care population amounts to just
21 over 35,000 people, while 4 percent of the
22 growth of population over the age of 75
23 amounts to over 50,000 people. So, you know,
24 there's lies, damn lies and statistics, and

1 this falls into the last.
2 Long term care growth is driven by
3 this aging population. They had been paying
4 unaffordable long-term-care rates
5 out-of-pocket, or family was sacrificing
6 their work and wages to provide that care.
7 Many seniors, particularly those in immigrant
8 communities, weren't aware of their
9 eligibility or were scared to use it until
10 outreach got them to sign up.
11 If folks get services who do not need
12 them, we should stop that. The state
13 contracts with Maximus to make sure that
14 people need the services they receive.
15 Before anyone can enroll in an MLTC to
16 receive long-term-care services through
17 Medicaid, they must be assessed by Maximus.
18 But the budget blames everyone except Maximus
19 for the growth in long-term-care spending.
20 Why? They have one job.
21 If we want to cover everyone and want
22 to provide the services they need, the state
23 needs CDPA. If the growth in CDPA were in
24 personal care, Medicaid would be paying

1 $200 million more per year than it is today.
2 If 25 percent of that population went to
3 nursing homes, it would cost us a billion
4 dollars more. The only way to trim
5 long-term-care expenses without cutting
6 access to benefits and services is to invest
7 in and encourage greater use of
8 consumer-directed.
9 In his budget address the Governor
10 noted that the personal care industry added
11 36,000 new jobs, or 75 percent of the new
12 jobs for New York City in the first nine
13 months of 2019. Despite the long-held
14 recognition that Medicaid is a primary driver
15 of local economies, this growth was
16 identified as a negative. However, the state
17 spent 6.9 billion on the Regional Economic
18 Development Councils. When the REDCs spend
19 money, they create transplants who gentrify
20 neighborhoods and cost poorer residents their
21 homes.
22 With CDPA, the state dollars invested
23 go to workers who live here today. People
24 are turning around and spending that money on

1 rent, food, and other local businesses. The
2 money stays here.
3 This is why CDPANYS stands with the
4 Caring Majority in calling for economic
5 development dollars to be invested not in
6 large companies, but in our Medicaid program
7 and other forms of human capital. We can use
8 these investments to offset the costs to
9 counties and the Medicaid program while
10 improving the quality of jobs we provide and
11 righting the wrongs of the past.
12 CDPANYS has additional ideas that
13 would more than pay for offsetting or
14 repealing the old funding formula that was
15 put in place last year and the draconian cuts
16 that have already happened. They total over
17 a quarter of a billion dollars, and we'll
18 share that with you offline.
19 CHAIRWOMAN KRUEGER: Senators, any
20 questions? Assembly?
21 Thank you very much for being here
22 with us, Bryan.
23 MR. O'MALLEY: Thank you.
24 CHAIRWOMAN KRUEGER: And I believe the

1 last person up for the evening who hasn't
2 given up on us is Center for Elder Law and
3 Justice.
4 And if anyone else in the audience
5 thinks they're testifying, come down here and
6 talk to someone.
7 Hello.
8 MS. HECKLER: Hi. Thank you for the
9 opportunity to testify and staying with me.
10 I was not about to drive back to Buffalo
11 before I got my little spiel.
12 (Laughter.)
13 MS. HECKLER: My name is Lindsay
14 Heckler. I am a supervising attorney with
15 the Center for Elder Law and Justice. We are
16 a nonprofit law firm that provides free civil
17 legal services to older adults, disabled and
18 low-income people of Western New York.
19 We are concerned about the lack of
20 transparency and public involvement in the
21 process of determining where to save funds in
22 the Medicaid budget and the budget at large.
23 We are specifically concerned about the
24 Governor's use of the Medicaid Redesign Team

1 and the backup plan to cut $2.5 billion if
2 MRT does not result in savings.
3 The intent of the Medicaid program is
4 to provide coverage and access to low-income
5 people and people with disabilities. The
6 program is a lifeline to many and ensures
7 that our older adults and people with
8 disabilities are able to live in the
9 least-restrictive setting of their choosing.
10 Contrary to the intent of the
11 Governor's budget address, where he blamed
12 the deficit on the Medicaid consumer program
13 and Medicaid managed long term care plans,
14 consumers are not a burden on the taxpayer.
15 Consumers are our parents, siblings, children
16 and friends and are an important and
17 essential part of our society. Their lives
18 should not be subject to politics.
19 The growth of Medicaid in New York is
20 not a surprise, and funding has been
21 repeatedly pushed off for future handling.
22 This is not the fault of the consumer.
23 Sudden changes and cuts to Medicaid without
24 thought to the consequences will lead to

1 consumers being harmed, wrongfully
2 institutionalized, and premature death. This
3 is not the New York we aspire to be.
4 During this difficult year we urge the
5 Legislature to oppose the Medicaid local
6 district spending reforms. Remember the
7 state's obligation under Olmstead for people
8 to live in the least-restrictive setting of
9 their choice. Ensure Medicaid consumer
10 representation on any potential changes to
11 the Medicaid program, and hold Medicaid
12 managed care plans and providers who accept
13 Medicaid accountable for controlling costs
14 and providing quality care and services.
15 The MRT process is like a
16 quasi-legislative panel whereby the
17 Legislature has limited authority and
18 responsibility for the budgetary changes to
19 Medicaid. The power to make such change is
20 with the Executive. With so much power being
21 under the Executive's authority, it is
22 essential that the consumer is involved in
23 decisions made to the Medicaid program. This
24 is their lives.

1 We also urge the Legislature to
2 remember New York's obligation under the
3 Olmstead Supreme Court decision, that persons
4 with disabilities have a civil right to
5 receive services in the settings of their
6 choosing. For a time, New York believed in
7 this and developed an Olmstead plan.
8 However, recent actions are taking New York
9 away from this important principle.
10 One example is the nursing home
11 carve-out that requires consumers who live in
12 a nursing home for more than three months be
13 disenrolled from managed care. This
14 incentivizes the institutionalization of
15 people with disabilities, young and old.
16 There is no incentive for MLTC plans to
17 enroll consumers who have high care needs.
18 Consumers already have a hard time returning
19 to the community from nursing homes. The
20 carve-out is going to make and is in the
21 process of making things worse.
22 Another example are the attacks on the
23 Consumer Directed Program. We urge you to
24 hold managed care plans and providers that

1 accept Medicaid accountable for controlling
2 costs and providing quality care and required
3 services. The majority of consumers who need
4 long-term care in the community are enrolled
5 in MLTC plans. As a result, the consumers
6 expect that these plans -- and we as
7 taxpayers expect -- that the plans ensure
8 access to the services they are supposed to
9 provide.
10 However, this is not the case, and we
11 are seeing consumers, in an effort to receive
12 some type of care at home, accept arbitrary
13 reduction in their hours and accept that
14 staff might not simply show up.
15 Consumers and others want and deserve
16 to remain in the community. Substandard
17 nursing home care in our state occurs too
18 often, and there is a lack of effective
19 enforcement of basic care standards by the
20 Department of Health. A recent example is a
21 facility in Genesee County where maggots
22 infested a resident's leg, not once but
23 twice. Can you imagine seeing your mother
24 with maggots going down her leg twice within

1 a week?
2 In closing, New York prides itself as
3 being the first state in the country to be
4 designated as age-friendly, and that older
5 adults are an economic powerhouse and that
6 health and well-being of all citizens is
7 essential for the state's overall social and
8 economic development. I ask, how long will
9 older adults be an economic powerhouse when
10 they're institutionalized, spend all their
11 resources on care, and leave the workforce
12 early to provide caregiving services to loved
13 ones?
14 New York cannot turn its back on
15 seniors and the disabled. It is not good
16 public policy to celebrate the expansion of
17 Medicaid and that 95 percent of the state is
18 covered by some form of insurance, then blame
19 those who use the coverage. Consumers and
20 caregivers are not to blame.
21 The cost of long-term care needs to be
22 addressed, but it should not be done to the
23 detriment of consumers. Thank you.
24 CHAIRWOMAN KRUEGER: Any questions?

1 No?
2 CHAIRWOMAN WEINSTEIN: Mr. Cahill.
3 ASSEMBLYMAN CAHILL: Ms. Heckler,
4 thank you for enduring this whole day and
5 staying as late as you do, and have a safe
6 trip back to Buffalo.
7 I just want to thank you for putting a
8 human face on some of the issues we've been
9 discussing today, and especially for
10 reminding us that we have a constitutional
11 obligation, a New York State constitutional
12 obligation for the general welfare of every
13 single human being who lives in this state,
14 and a court-imposed obligation to take care
15 of people who are elderly and disabled and
16 make sure that they are in the
17 least-restrictive setting possible.
18 So thank you for your testimony.
19 MS. HECKLER: Thank you.
20 CHAIRWOMAN KRUEGER: Thank you very
21 much.
22 This draws to conclusion our budget
23 hearing on Medicaid and healthcare issues.
24 Thank you all who are watching from home or

1 from here.

2 Tomorrow morning's hearing on

3 Human Services starts at 9:30. Same room,

4 same channels. Thank you all.

5 (Whereupon, the budget hearing concluded

6 at 8:46 p.m.)

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