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

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JOINT LEGISLATIVE HEARING

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

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Hearing Room B
Legislative Office Building
Albany, New York

January 29, 2020
9:34 a.m.

PRESIDING:

Senator Liz Krueger
Chair, Senate Finance Committee

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

PRESENT:

Senator James L. Seward
Senate Finance Committee (RM)

Assemblyman Edward P. Ra
Assembly Ways & Means Committee (RM)

Senator Gustavo Rivera
Chair, Senate Committee on Health

Assemblyman Richard N. Gottfried
Chair, Assembly Health Committee

Senator Neil Breslin
Chair, Senate Insurance Committee
PRESENT: (Continued)

Assemblyman Kevin A. Cahill  
Chair, Assembly Committee on Insurance

Senator Patrick M. Gallivan

Assemblyman Kevin M. Byrne

Assemblywoman Rodneyse Bichotte

Senator Brad Hoylman

Senator Diane J. Savino

Assemblyman Edward C. Braunstein

Senator Todd Kaminsky

Assemblyman Nader J. Sayegh

Senator Rachel May

Assemblyman Phil Steck

Senator Zellnor Myrie

Assemblywoman Marjorie Byrnes

Senator Elizabeth O’C. Little

Assemblyman Andrew Garbarino

Senator Anna M. Kaplan

Assemblyman Jonathan G. Jacobson

Assemblyman John McDonald

Senator Alessandra Biaggi

Assemblywoman Linda B. Rosenthal
PRESENT: (Continued)

Assemblyman Jake Ashby
Senator Patricia A. Ritchie
Assemblywoman Michaille Solages
Assemblywoman Patricia Fahy
Senator John C. Liu
Assemblywoman Judy Griffin
Assemblyman Félix Ortiz
Senator Jen Metzger
Assemblyman John Salka
Assemblywoman Marianne Buttenschon
Senator Susan Serino
Assemblyman Thomas J. Abinanti
Assemblywoman Aileen M. Gunther
Senator Robert Jackson
Assemblywoman Melissa Miller
Assemblyman Charles Barron
Assemblyman Michael Blake
Assemblyman Philip A. Palmesano
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CHAIRWOMAN KRUEGER: Good morning, everyone. If people could get a chair and get comfortable, this is the hearing on Health.

We suggested last night, if people were listening, that people might want to bring sleeping bags or pajamas to today's hearing; we expect it to go very late this evening. Because of that, we have established some rules for hearings that we are trying to be fairly strict about, mostly relevant to those of us in the Legislature.

But the first one, please pay close attention to the clock. All right? The government testifiers get 10 minutes to testify. Then after we get past the government testifiers, people have five minutes to testify. We will cut you off.

We encourage you, especially people who aren't going to be testifying until much later today, do not read your testimony. People have some fantasy that they have 20 pages and they can get through it in five minutes. It's just never been true.
So we all get copies of everyone's testimony. It goes up on the hearing site for the public to have access to as well. What we hope you will do is bullet point the key issues within your testimony, and don't find yourself in a situation where you made the most relevant parts of your very long testimony the last few pages, which you will never get to. So start in the back if that's what you did in your written testimony.

Again, we are legislators; we have all successfully learned to read.

Okay. The chairpersons of the relevant committees have a 10-minute allotment for questions and answers of government witnesses; all other legislators have five minutes of government reps. Except for the relevant chairs -- for example, Health for our first group of panelists, the Health chairs will get a second opportunity of five minutes each, that's it.

Any legislator who feels the need to ask additional follow-up questions, you can present them to Helene or myself and if we
can fit them in in the time we have, we try
to bat cleanup and cover issues that people
didn't feel they had a chance to ask.

    When we shift to nongovernmental
witnesses many hours from now, legislators
will have -- sorry. When we get to
nongovernmental witnesses, again, you have
five minutes, but the legislators have three
minutes to ask you questions.

    And then finally there are some
legislators who know that they really have
important questions and they still want to
get follow-up from the panelists, or the
panelist said "I'll get back to you with
that." We ask: Feed those questions into us
legislators and a letter will go out from
Helene and myself to do the follow-up to
that. We get it back to the committee and
will make it public to everyone.

    And if you have questions as
individual legislators, if you would also get
them to Helene and I, we will make sure they
go out and that all members -- because if you
have a really critical question you were
homing to get the answer to, I'm going to bet
most of your colleagues want to know the
answers as well.

Okay. So before I kick -- oh, no, now
I'm going to kick off the hearing. So hi,
I'm Liz Krueger, the New York State Senate
Finance Committee co-chair of today's budget
hearing. Helene and I -- Helene Weinstein,
Ways and Means chair, trade off every day
who's running the hearing, and this one is
the Senate's.

Today is the third of 13 hearings
conducted by the joint fiscal committees of
the Legislature regarding the Governor's
proposed budget for state fiscal year 2021.
These hearings are conducted pursuant to the
New York State Constitution and Legislative
Law.

Today the Senate Finance Committee and
the Assembly Ways and Means Committee -- we
should both have the same name for our
committees, it would be easier. Sorry --
will hear testimony concerning the Governor's
proposed budget for the Department of Health,
the Office of Medicaid Inspector General, and
the Department of Financial Services.
Following each testimony -- again, as was
just explained -- there will be time for
questions of the panelists by the
Legislature.
I will now introduce members from the
Senate and Assemblymember Helene Weinstein,
chair of the Assembly Ways and Means
Committee, will introduce members of the
Assembly. In addition, Senator Jim Seward,
ranking member of the Senate Finance
Committee, will introduce members of his
conference. I also want to recognize
Assemblymember Ra -- we didn't put you in our
speech, I apologize -- the ranking member for
the Assembly Republicans and a brand-new
member of this panel.
Okay, so representing each agency,
just briefly, I'd like to welcome Dr. Howard
Zucker, Donna Frescatore, Medicaid Director,
Department of Health. Dr. Zucker is
Commissioner of Health. And later we will
hear from Dennis Rosen, Medicaid Inspector
General, and Linda Lacewell, Superintendent of the Department of Financial Services, and they will each -- their testimony will be followed up with questions from the Legislature.

Okay, so introductions. I have with me today Senator Breslin, who is the chair of Insurance; Senator Todd Kaminsky, Senator John Liu; Senator Gustavo Rivera, chair of Health; Senator Brad Hoylman, Senator Diane Savino; Senator Rachel May; Senator Jen Metzger; Senator Myrie.

And would you like to introduce yours?

SENATOR SEWARD: Yes. Thank you. I'm pleased to introduce the members of my conference who have joined us here this morning. First of all, our ranking member of the Health Committee, Senator Gallivan. And also with us today is Senator Betty Little and Senator Sue Serino.

CHAIRWOMAN KRUEGER: Great. Assembly.

CHAIRWOMAN WEINSTEIN: We have with us the chair of our Health Committee,
Mr. Ra, to introduce the Republican members of the panel.

ASSEMBLYMAN RA: Thank you. We have with us the ranking member on the Health Committee, Assemblyman Kevin Byrne; our ranking member on the Insurance Committee, Assemblyman Andrew Garbarino; our ranking member on the Aging Committee, Assemblyman Jake Ashby; as well as members of the Health Committee, Assemblywoman Missy Miller and Assemblyman John Salka.

CHAIRWOMAN WEINSTEIN: And we were joined by Assemblyman Braunstein also.

CHAIRWOMAN KRUEGER: So, Dr. Zucker, if you would please start your 10 minutes of testimony.

COMMISSIONER ZUCKER: Thank you very much. Good morning, Chairpersons Krueger and Rivera, Weinstein and Gottfried, and members of the New York State Senate and Assembly.

I am here to present Governor Cuomo's fiscal year 2021 Executive Budget as it
relates to the health of all New Yorkers. I
am joined by Donna Frescatore, the State
Medicaid Director and Director of the
New York State of Health.

As you are aware, New York State faces
a significant budgetary challenge this year.
But from the perspective of the Department of
Health, challenges are everyday events and
not things that bring systems to a halt.
Just last year the state experienced the
largest measles outbreak in 30 years,
primarily in New York City and the Lower
Hudson Valley area.

The outbreak and the department's
response were unprecedented in our measles
elimination era. The department collaborated
with our local health and community partners
to combat the outbreak through education,
contact investigations, and ultimately the
administration of nearly 85,000 doses of the
MMR vaccine -- mumps, measles and rubella
vaccine -- in the affected counties.

The Governor signed legislation
removing vaccination exemptions that could
have made the outbreak worse, and we thank
our partners in the Legislature for that
effort. In the end, we successfully
contained an aggressive outbreak and stopped
the United States from losing its measles
elimination status.

But before we even had the chance to
exhale, we found ourselves face-to-face with
a new health threat, a severe pulmonary
illness associated with the use of vaping
products. The challenges here were twofold:
legal e-cigarette flavorings that hook kids
on nicotine through predatory marketing, and
the dangerous vaping products sold in the
illegal, unregulated market.

The department led with a vigorous
response consisting of regulations to ban the
sale of flavored e-cigarettes, public
education, case investigations, laboratory
testing, and a series of proposed
legislation.

Our own Wadsworth Center was the
nation's first laboratory to identify vitamin
E acetate in the illicit vaping products as a
likely source of this illness. Our discovery
framed a national narrative and led to
accolades from the Centers for Disease
Control.

And now, just a few months later, we
are doing the same with the evolving threat
of the novel coronavirus. Internally, the
department had it pegged as a likely new
coronavirus when it was still being labeled
internationally as a mysterious pneumonia
virus. It was nowhere on the health radar
even two months ago, and now we're once again
at the forefront of the issue.

The ongoing and new challenges met and
addressed by the Department of Health are
manifold -- Zika, Ebola, and C. auris, which
is the medication-resistant infection that's
increasingly being identified in long-term
healthcare settings. Two years ago, on the
100th anniversary of the 1918 influenza
pandemic, we experienced one of the worst flu
seasons since we began tracking in 2004. And
this year we again are facing an
uncompromising influenza season, while
tackling a hepatitis A outbreak in several parts of the state. And when it gets warmer, we will collect and test over 100,000 ticks to combat the ongoing challenge of Lyme disease.

We are not just reactive to public health challenges, we are proactive -- taking action and making investments to protect drinking water from contaminants, investigating counties with atypical cancer rates, and implementing strategies to prevent maternal mortality. The department always puts public health first, period.

We in New York know that access to healthcare is critical. Today 95 percent of the state's residents have health insurance. That's over 18 million New Yorkers. Critical to this achievement is the 2014 launch of New York State of Health, which provides crucial low-cost and no-cost health coverage to 4.8 million people, one in four New Yorkers. Enrollment in the New York State of Health is still open, and in fact we just extended it for an additional week. But
already this year's enrollment is at its highest point ever.

Under Governor Cuomo's leadership, this agency is always prepared for the next challenge, the next public health threat, the unexpected, because we know we are never done with what we're doing.

Pivoting to Medicaid, it is true we have a structural deficit this year, but we have met these challenges before. In 2011, Governor Cuomo created the first Medicaid Redesign Team, which successfully developed a series of recommendations to immediately lower costs, increase efficiencies and effectiveness, and generally improve the program. We have demonstrated that our Medicaid program can achieve both comprehensive coverage for those who need it and financial sustainability. Although the healthcare landscape throughout the country has changed, New York's commitment to delivering high-quality healthcare to more than 6 million residents has not.

We must now recalibrate to ensure that
the original reforms are working as intended
and to innovate new solutions in order to
rise up to meet the changing landscape and
the changing demographics. To that end,
Governor Cuomo has announced that he is
reconstituting the Medicaid Redesign Team.
Through its stakeholder-led approach, MRT II
will advance new recommendations to reform
the state's Medicaid program, preserve
benefits, and identify $2.5 billion in
structural savings and efficiencies.

When circumstances are ideal, we can
use the benefits of greater efficiencies and
innovations to grow, experiment and do more.
But in times of hardship, we must come
together to ensure that these benefits are
preserved for those who need it most.

As I said at the start of this
testimony, this is a challenge, but it is one
we are uniquely prepared for. And we are
looking to you to be a partner in that
effort.

I am grateful for the opportunity to
share this information from the department.
We are happy to take your questions. But please know that you will have further opportunities after today, after this hearing, to get the information you are seeking. Our respective staffs are always working together on these issues, and we'll remain in close contact as we rise to this challenge.

Thank you.

CHAIRWOMAN KRUEGER: Thank you. Our first questioner will be Gustavo Rivera, chair of the Senate Health Committee.

SENATOR RIVERA: Thank you, Madam Chair.

Good morning to both. Let's get right into it.

First of all, the original process -- please correct me if I'm wrong, but the original MRT process that happened in 2011 started with an Executive Order that impaneled, so to speak, the MRT and then was given specific instructions so that by March 1st of that year there would be recommendations so the Legislature would have
a month to consider this before being
implemented in the budget. Is that correct?

COMMISSIONER ZUCKER: That's correct.

Correct.

SENATOR RIVERA: It is now
January 29th. Let's just make sure that we
check that date. Has there been an
Executive Order issued by the Governor to
empanel the MRT?

COMMISSIONER ZUCKER: Not yet. We are
working on it. We are working on it.

SENATOR RIVERA: Gotcha. Could you
tell me, outside of the Aid to Localities
budget, which is an 818-page document that
refers to the Department of Health,
outside -- is there any direct reference to
the MRT in the actual budget language? It's
a trick question, but I'll let you answer it
anyway.

MEDICAID DIRECTOR FRESCATORE: I
believe there's reference in the book. I
don't know if there is in the financial plan
specifically.

SENATOR RIVERA: Microphone a little
bit closer, please? I can't hear you.

MEDICAID DIRECTOR FRESCATORE: Yeah,

I'm sorry. Good morning, Senator.

SENATOR RIVERA: Good morning.

MEDICAID DIRECTOR FRESCATORE: I believe there's reference to it in the budget documents. I don't know that there is reference in the financial plan.

I think we've been certainly at the department for many months very clear that the successful results we had from the convening of the first MRT back in 2011, which saved taxpayers, you know, tens of millions of dollars --

SENATOR RIVERA: That's -- excuse me.

Since I have limited time, I will say for the record the first MRT might not have been perfect, but it achieved great things. So let's not talk about that one anymore, let's talk about the one that we're supposedly putting together now.

MEDICAID DIRECTOR FRESCATORE: Fair enough.

SENATOR RIVERA: Outside -- and I said
it's a trick question because outside of references in like 15 different pages, there's a particular language that does not refer at all to an MRT. What it does -- in other words, a Medicaid Redesign Team. There's no actual mention of a Medicaid Redesign Team. As opposed to that, there is language -- I'm going to read some of it into the record: "If on or before April 1, 2020, the Legislature fails to achieve $2.5 billion in aggregate savings from the appropriate appropriations enacted as part of any chapters of the Laws of 2020" -- making appropriations for the Aid to Localities, et cetera, et cetera, de-de-de-de, and then it goes on to "uniform across-the-board reductions shall be applied to such appropriations to achieve $2.5 billion in aggregate savings."

This is the question -- I wanted to make sure we got to this point because we -- what detail do we actually have? For the moment there is the mention of the MRT. What is going to be the -- who are going to be the
members of the MRT? Could you tell us today, please?

COMMISSIONER ZUCKER: At this point we are working on that, and we will get that back to you quickly.

SENATOR RIVERA: Okay. Again, February -- I'm sorry, January 29th, right? We're working on a timeline here. So --

COMMISSIONER ZUCKER: I will say that we will -- we are going to look at all -- as they did when they did the first MRT, look at all the stakeholders who have an interest in this will be represented, obviously the Legislature as well --

SENATOR RIVERA: I was going to get to that.

COMMISSIONER ZUCKER: -- and obviously the legislators as well, and we will work forward to address the changing landscape and make sure there are any things that -- when the first MRT was put together, things were a little bit different.

SENATOR RIVERA: Got you. But as of January 29th, we do not know who the members
are going to be. That's number one. We
don't know. Right? You all might know, but
we don't know.

Number two. The powers that this MRT
is going to have, there's no specificity of
it here. Right? Am I correct in that? Or
am I not -- am I missing something?

COMMISSIONER ZUCKER: We'll work all
this out. This is an ongoing process.

SENATOR RIVERA: All right. Third,
the timeline. It seems to me that the
timeline that's put here is completely
unrealistic, particularly since it is now,
again, January 29th and we don't have any
details.

So I just -- this is -- because
there's a couple of other things that I want
to cover, and I want to make sure that I get
some time. But this is the bottom line, and
I just want to make sure that this is a
publicly stated thing. We get it in the
Legislature, we get it, that there is a
crisis here and that we have to work together
to solve it. The best way to do that is to
It is a little bit concerning --
scratch that -- a lot very concerning that
you are coming to a public hearing on
January 29th and you're telling us that by
April 1st we have to just accept something
that's going to be put together by a magical
crew of folks -- we don't know who they are,
we don't know the power that they have.

The timeline that they have is either
we accept it or, according to this language,
there's just an across-the-board cut. That
is not acceptable. And I'm saying it both to
you, as representatives of the Governor, and
I'm saying it to the Governor. It is not
acceptable that this is what you're asking us
to do. That's number one.

Let's get to the second part, which

COMMISSIONER ZUCKER: Let me just
respond to you about the timing issue.

SENATOR RIVERA: Please.

COMMISSIONER ZUCKER: I mean, the
department has risen to the occasion, and the
entire administration, on many issues. And
even though you feel April 1st is right
around the corner, we will -- we will rise to
the occasion again and address all these
issues and move it forward as quickly as
possible and work quite diligently and quite
hard and long hours to get that done.

SENIOR RIVERA: Beautiful. Can I get
a commitment that we will -- like in 2011,
can we get a commitment that the Legislature
would have something to consider by March 1st
of this year?

COMMISSIONER ZUCKER: Well, I don't
want to commit to a day or a time, but -- but
we will -- we can get back to you on that,

exactly the time.

SENIOR RIVERA: So I will say
again --

COMMISSIONER ZUCKER: I understand.

SENIOR RIVERA: -- we -- it would be
preferable that we have some time as a
Legislature to look at whatever solutions.
And more importantly, as you referred
earlier, that we have a role in determining
what those policies are. We would love to be participating.

And I know that many folks in this room, the stakeholders -- since you talk about stakeholders here, but there's no clear line of who those stakeholders are. And there's many stakeholders that need to be part of that process.

Moving on. Let's talk about the Aid to Localities thing. There is a way that you are suggesting that localities across the state would be penalized if they don't meet certain criteria, so I just want to talk about that for a second. Do we have -- there is the issue of the 2 percent and the 3 percent. Right? That if a locality is underneath the 2 percent property tax cap, and then there's a 3 percent growth or less, that they would be able to recoup some of these savings that they recouped to the state --

COMMISSIONER ZUCKER: If they stay under that.

SENATOR RIVERA: Very well.
Can you point to me language in the budget that actually lays out how a locality would do that, number one?

COMMISSIONER ZUCKER: I'll go back and look at that.

SENATOR RIVERA: Yeah. Trick question again. Ain't there. All right? It's not there. So you say that it is, but a press release does not reality make. So I need to know how the localities would do that. And more importantly, what data are you relying on that tells you -- there's 62 counties, right, five of them in the City of New York. So do you know -- could you provide us with the data, because you haven't so far -- but maybe you did today, I don't know. Can you provide us with the data that tells us what counties actually fall within the criteria that you established?

COMMISSIONER ZUCKER: We can get you that, exactly which counties.

SENATOR RIVERA: Again, thank you, I guess. Ma'am.

MEDICAID DIRECTOR FRESCATORE: Well,
thank you. I mean, I'd like to -- you know,

I'd like to just, if I can at this point --

SENATOR RIVERA: Please.

MEDICAID DIRECTOR FRESCATORE: -- talk

a little bit about -- in response to your
question about what would you expect from
localities. And there is in the financial
plan a chart that shows, by locality, the
amount of Medicaid spending that has been --
that has been assumed by the state since the
takeover of the growth.

And I think you know those statistics,

Senator, that it's -- that for a number of
years the local contribution has been frozen,
if you will, at $7.6 billion, with
New York -- with the state assuming about
$4 billion a year in the additional growth of
the Medicaid program since that point in
time, cumulatively about --

SENATOR RIVERA: Since I have two
minutes -- I'm sorry to cut you off again.
I'm just going to be -- since they used --
since localities used federal and state
guidance on who is eligible, I'm not sure
that they have any discretion to determine who's actually on their rolls or not. So how is it that they're going to be held responsible for things that they don't necessarily have control over?

MEDICAID DIRECTOR FRESCATORE: Yeah, so just maybe to level set here, locals make about 47 percent of the eligibility determinations. They're largely for people who are in need of long-term care; people who are eligible for Medicare and Medicaid, dually eligible; and other individuals such as people with excess income that spend down to Medicaid.

And while for all of us Medicaid eligibility is spelled out largely in federal and state law, day to day we partner with the locals in applying those rules and those eligibility criteria.

And really what these proposals are intended to do is to bring the districts and my folks within the Office of Health Insurance Programs to the table in partnership to find savings and efficiencies.
The other important --

SENATOR RIVERA: Gotcha. I've got one minute left, so I'm just going to -- I'm going to cut you off. Just to -- one last thing I want to -- just want to make sure that we're on the record about.

So again, the MRT was a good thing overall. It managed to flatten cost curves, et cetera. The program kept existing. Can we all get on the same -- can we all agree that the formula that was created 10 years ago is not -- is not operational anymore? If I'm not mistaken, if we look at the numbers, the cap has been pierced on basically every year for the last, what, four or five years.

The question here is, do we need to revisit whether the cap is a good idea? And if it is, should we not revisit the formula so that we're not -- because the reason -- because the reason that we're where we are is that we set this artificial cap -- yes, it's statutory, but we can move it, and then we'd no longer find ourselves in a place where we have to cut everything that you've cut
already, which, you know -- I'm going to come back for five minutes later, so other folks are going to go at you.

But just the last thing that I'll say, it is not acceptable that you're not bringing details to us that can help us make better decisions about what this budget is going to be. But I'm going to come back in a little bit and --

MEDICAID DIRECTOR FRESCATORE: Okay, and I'd like to address the question about the cap, if I can, right here.

CHAIRWOMAN KRUEGER: The time is up for this period. So I think you will have more opportunities to answer about the cap, because I suspect other people will also focus on that.

And now it is the Assembly.

CHAIRWOMAN WEINSTEIN: We'll go to Assemblyman Gottfried for 10 minutes.

ASSEMBLYMAN GOTTFRIED: Thank you.

(Off the record.)

CHAIRWOMAN KRUEGER: Something else I forgot to mention, mostly to my colleagues in
the two panels here. Make sure your mike is
off when you're not the one talking, because
they're hot and people who are watching on
line are listening to every conversation.
And they don't really want to, they just have
no choice.

But so watch your mikes, that they're
on when they're supposed to be, and off,
because you never know who's listening.

(Laughter.)

ASSEMBLYMAN GOTTFRIED: Thank you.

And speaking of microphones, given the pretty
crummy acoustics in this room, it would
really be better if you could make an extra
effort to speak right into the microphone,
and louder, because otherwise it's really
hard to hear.

So a couple of questions. In 2011 the
MRT had its first meeting in mid-January. In
five or six weeks, beautifully produced
binders came out with about 80 proposals.
People had submitted hundreds of proposals,
but the ones that made it into the package
were chosen behind closed doors by executive
branch staff.

That package was presented to the MRT meeting and approved on the spot. Within a few days, dozens of pages of carefully drafted bill text appeared and became amendments to the Article VII bill.

The rhetoric was that the MRT package came together in a wonderful process of public input. Any serious observer would have understood that almost the entire package had actually been worked out weeks before, behind closed doors, by the incoming administration, working with a selected group of interest groups, and the whole MRT process was just political theater.

My first question is, why would anyone believe MRT II will be any different?

COMMISSIONER ZUCKER: I'll start by saying that MRT I came together, I think that we all would agree that it was successful in what its mission was to achieve. And I do believe that as we move forward with MRT II, there will be collaboration and communication with all the, as I mentioned before,
stakeholders to achieve the goals of addressing the changing landscape that has happened since 2011 to 2020.

And I think that if there are specific concerns, we will clearly address them. And if there are things that you felt could have been done differently the first time around, as some of the things you mentioned here, I'm sure that that will be entertained as we move forward.

Donna, do you want to --

MEDICAID DIRECTOR FRESCATORE: No, I don't have anything to add. But we hear those concerns, and it is our intent to have full participation of all of the members of the MRT, including the legislative representatives, that we expect -- fully expect will be part of our discussion.

ASSEMBLYMAN GOTTFRIED: But the question I asked was is the cake batter not only all mixed, but it's been in the oven and we're now putting the icing on it before the MRT has even been named?

And I'm -- I don't think any serious
observer could doubt that that was the process in 2011, and I see no reason to doubt that that's not the process this year.

COMMISSIONER ZUCKER: We are working on identifying the members of the MRT II. And obviously when everyone's -- the committee is formed, then they will come together to discuss many of the issues that have been raised.

And, you know, we have nine years worth of time behind us now regarding many of the challenges that the state has faced, and we will move forward from there. And as I said before, that that was the goal initially in 2011, to move forward, address the un -- the incredible increase in costs to Medicaid. The Governor and the team tackled that at that time, moved forward. I think that was a success on MRT I. As I mentioned before, things have changed. We'll tackle it again.

ASSEMBLYMAN GOTTFRIED: Okay, the administration has invented the slogan "blank check syndrome" to blame New York City and counties for much of the growth in Medicaid
spending and to justify imposing hefty financial penalties on them. But my understanding is that those local governments only approve the enrollment of a portion of Medicaid enrollees following federal and state rules. DOH and DOH's Medicaid inspector general can audit all of that and can overturn any inappropriate enrollment. The city and counties have no say in which services an enrollee receives or how much of that service, such as hours of home care, the enrollee receives or how much providers are paid.

All those determinations are made by DOH or by Medicaid managed-care plans and managed long-term-care plans under rules set by DOH. And a lot of very knowledgeable people tell me the same thing.

So my second question is, how can the administration justify imposing hefty financial penalties on the city and counties for actions they don't do and have no control over?

MEDICAID DIRECTOR FRESCATORE: So if
Dr. Zucker would like, I can respond to it.

Again, what these proposals are intended to
do is create a partnership with the local
districts, which share in the administration
of the Medicaid program. I already talked
about the 47 percent of applications for
Medicaid eligibility that the local districts
process. Those are, you know, complicated
applications. I listed off the types of
applications in response to Senator Rivera.

But there's one other very important
role that the districts play, and that is in
actually managing care for people who remain
in the Medicaid fee-for-service program. I
just wanted to put some of the facts out
there, and statistics, about that.

So persons who are in fee-for-service
and need long-term-care services and either
they aren't eligible to join a managed
long-term-care plan or they need short
duration services, that care is managed
and -- that care is managed by the local
district. The local district gets the
request, they do a nursing assessment, they
do a social assessment of the individual in their home, they determine the plan of care.

And in fact, statewide there's about 907,000 or so people in the Medicaid fee-for-service program where the local district is managing just that personal care and the long-term-care services, so specifically the personal care services and consumer-directed.

They approve, at the district level, about 2.2 million hours of care every month at a monthly cost of about $1.3 billion. So as a matter of fact, I would submit the local districts have a very active and ongoing role in determining not just the 47 percent of the people and whether they're Medicaid eligible, but what services they get. And as we know from the data that we've looked at and we've all seen over time, a particularly important role in the long-term-care-service approval space, which is the fastest-growing component of Medicaid spending.

There's additionally some other activities that the local districts do around
some special populations that, you know, are
not as significant in terms of members and
dollars as long-term care, and they have a
role in investigating consumer waste, fraud
or abuse as well.

ASSEMBLYMAN GOTTFRIED: Well, I would
ask, when you use language like "blank check
syndrome" -- and, you know, I never went to
medical school, but I think "syndrome"
implies some kind of sickness. That
implies -- more than implies that something
bad is going on, that local governments don't
really care, and so they're handing out
Medicaid enrollment just willy-nilly to --
you know, like candy.

Is there any shred of evidence of that
kind of misconduct? Does the -- has the
department had to like put on extra staff to
revoke a lot of those enrollments because you
find that they're unjustified? I think I
know the answer to that question. But is
there any evidence that localities are doing
something wrong in this process and therefore
need to be slapped down?
MEDICAID DIRECTOR FRESCATORE: So I would defer the definition of "syndrome" to our health commissioner, my favorite doctor.

But on the other matter, this isn't -- this isn't an allegation about the districts doing anything wrong. This is just the facts around the responsibilities that local districts have for administering Medicaid and our desire to bring them back to the table, work with them to align incentives with growing costs. And we have certainly had districts that come to us with ideas, whether it's about improving eligibility processes, using new databases to make certain people don't have income they have not disclosed, about novel ways to put care plans in place that work for consumers and save -- you know, efficiently use Medicaid dollars.

That's what this is about. This isn't about placing blame. Frankly, we could all go through audit reports and findings and find someone somewhere who had some role in administering the Medicaid program made an error. But that's not what this is about.
This is about partnering to, once again,
bring the growth in the program into an
allowable tolerance so it's sustainable for
everyone.

ASSEMBLYMAN GOTTFRIED: Okay, we'll --
we may come back to this.

CHAIRWOMAN WEINSTEIN: Senate.

CHAIRWOMAN KRUEGER: Thank you.

SENATOR SEWARD: Thank you, Madam
Chair, Commissioner and Ms. Frescatore.

Just for the record, I just want to
say that I share some of the concerns that
have been expressed by the two chairs already
this morning in terms of MRT II. There's an
extremely limited time frame involved here,
and a huge job and responsibility and
challenge. And I do have concerns about the
necessary transparency and legislative input
through the process as well as the
participation of consumers and other health
advocacy groups and providers, other
stakeholders, in the deliberations of MRT II.

With that thought in mind, in the
first MRT process EMS did not have a seat at the table. And EMS has emerged as a critical component of the healthcare continuum. There's a lot that goes on in that ambulance on the way to the hospital or another provider.

And my question is, will EMS have representation on MRT II? I think it's critically important that they do.

COMMISSIONER ZUCKER: So as I mentioned before, all the stakeholders that need to be involved will get involved on MRT II. And I echo your words about EMS and the unbelievable amount of effort and the millions of individuals who utilize those services.

And I will be the first to admit that some loved one in my own family this year used EMS in an emergency. And I realize what goes on in the back of those ambulances, both as a professional as well as a relative this past year.

So we will make sure all of the stakeholders are there. And as I said,
things have changed, the landscape has changed. We will rise to the occasion again and address it as needed.

SENATOR SEWARD: Thank you. I hope you'll follow through on that because it's lifesaving and life-enhancing what goes on in that ambulance. And they should be at the table.

I wanted to shift gears on the additional surcharge on the Certificate of Need, the 3 percent that was included in the Governor's budget. How many CON applications does DOH process annually? And is -- I have concerns that by simply adding another surcharge on the CON applications that those costs will simply be passed down to consumers and exacerbate the already high healthcare costs.

COMMISSIONER ZUCKER: So I can't give you the answer of how many, but I can tell you it is an enormous amount, because every month when we meet before the PHHPC committee and I go through and hear about all the Certificate of Needs, they are quite
expansive.

I will say there will be the exception -- be the opportunity to have exceptions for those Certificate of Need applications as we move forward. Also I will mention that just the complexity and the volume of those Certificate of Needs has increased over the course of -- at least during the six years I've been in this role.

SENATOR SEWARD: Do you have concerns that the estimated $70 million in revenue from this new surcharge will be $70 million of additional costs for the healthcare system?

COMMISSIONER ZUCKER: Right, it will -- that will be -- it's not going to -- it's going to help the system in general, in the big picture. So I am confident that's where it will go.

SENATOR SEWARD: You're saying the surcharge will help the system?

COMMISSIONER ZUCKER: Well, I'm saying the surcharge will be -- I mean, this is some of the resources that we need to move things
forward. But overall, it helps the system in
an effort to try to provide the amount of --
the complexity of these applications and to
move them through faster and quicker.
Because we've heard a lot of people asking,
saying, Well, I still haven't received my
Certificate of Need. And so we try and move
the system to make it more seamless.
SENATOR SEWARD: I would just
reiterate, my concern is that the $70 million
will be passed on to healthcare consumers,
and that concerns me.
My final question has to do with the
Rural Health Program consolidation that's
part of the budget. This is not a lot of
money, but it's critically important to the
rural areas, consolidating the Rural
Healthcare Access Development Program and the
Rural Healthcare Network Development into one
program with a 25 percent cut.
What's the rationale for eliminating
these important programs in high-need rural
areas of our state?
COMMISSIONER ZUCKER: Well, I don't
feel that we are eliminating -- that we're not interested in the issue of rural health; in fact, that we have made an incredible commitment on this issue, particularly in the North Country. I can tell that we are working diligently to try to sort that out.

And we are also aware of the challenges in rural health, which is a way different -- many different issues, particularly when it comes to travel, distance, EMS, that you just brought up before. And we're trying to figure out ways to help all people in the state, particularly those in the rural area.

SENATOR SEWARD: Thank you. My time is up.

CHAIRWOMAN KRUEGER: Thank you. Assembly.

CHAIRWOMAN WEINSTEIN: We've been joined by Assemblywoman Fahy, Assemblywoman Solages, Assemblyman Jacobson, and we go to Assemblywoman Bichotte.

ASSEMBLYWOMAN BICHOTTE: Thank you, Commissioner. Thank you, both of you, for
being here today. Some of the questions that I'm going to be asking were probably asked earlier, but my constituents would like to hear just a brief answer to these questions.

The first question -- the first couple of questions is the budget asks the local municipalities to contribute more money towards Medicaid. However, it does not give the local municipalities more control over what the providers can charge, which services they deem unnecessary or duplicative. The question is, how can you hold me, let's say, the local, responsible for something without giving me control of the spending? It's like saying, I'll take your credit card and spend how I wish, but don't tell me what to do with it. So that's an issue.

And part two of that is with the Medicaid Redesign Team, we talked about who we would like to be part of that. In terms of groups, do you have a sense of what groups will be part that? For example, like nursing homes, hospitals, home care agencies, ambulance -- I heard it earlier, EMS is very
important. That's very important to me as well -- unions, large unions like 1199 and NYSNA. What kind of groups are you thinking to be part of the MRT? Again, this is high level.

COMMISSIONER ZUCKER: So I'm going to address the second question, and Donna, you can address the issue on local share.

I will tell you that since 2011, the challenges that the state has faced on certain issues of healthcare have changed. Long-term care has increased significantly. The aging population of the state has also gone up in percentage. And we recognize that when we move forward on the issues of MRT II, that those who represent those interests will need to be part of the mix.

In addition to that, in 2011 people were -- the amount of home care was different. The nursing home issues were different. It was a completely different, as I mentioned before, landscape at that time.

So when we move forward with MRT II, we'll make sure that those who have an
interest in those particular challenges that we face as a state will be represented, to be sure that the next plan moving forward addresses their needs.

And on the local share, did you want to comment?

MEDICAID DIRECTOR FRESCATORE: Yeah, I think I -- I don't want to take time if you feel it's already been answered. But we talked about the 47 percent of the applications that are processed by the district just in home care services, personal care services specifically, and consumer directed. That about 900,000 people who remain in the fee-for-service program have care plans developed by the local district.

The regulation, if you're going to look at the personal care regulations and the consumer-directed program regulations, they're very clear about the local district's role, which is to do the assessment and develop the care plan, if there's a disagreement, represent the Medicaid program at a fair hearing to defend the decisions.
they've made.

Again, the local districts taken collectively, just on that service, approve about 2.2 million hours of care per month at a cost of about 1.3 billion a month. So times 12, that gives you an idea of -- just for those services.

So -- and there are some places -- to address your specific question, Assemblywoman, there are some limited places where the reimbursement rate is also set by the local district, most notably New York City, for personal care and consumer-directed services. That reimbursement rate is set by the city. For many, many years that's been in place; not something new.

ASSEMBLYWOMAN BICHOTTE: Well, thank you. And I will follow up more on details. I do have limited time, so I have a few questions that I'm just going to bundle. When it comes to maternal mortality, thank you for addressing that in your briefing. I just want to know like who's getting the contracts for maternal mortality
training.

Also just, you know, I am a victim of, you know, having to lose my baby. I almost died. And I notice that one of your board members was actually the supervising doctor of the doctor who turned me away when my baby was protruding out, from Columbia Hospital. I'm requesting that they do not represent on the board.

And I want to assure that we need to look at the discrimination against black and Latino pregnant women.

The next thing I quickly want to touch base on is tobacco. I know you talked about the flavored e-vaping. We certainly want to also address the flavored tobacco that also have been racially targeting communities of color. And if we take away the flavored e-vaping, our kids are now going to go to flavored tobacco. We're not taking tobacco away, we're just taking the flavored part, and we need people to know that. And we're hoping the state is not being bought by the Big Tobacco, R.J. Reynolds.
COMMISSIONER ZUCKER: So I'll -- can
I --

CHAIRWOMAN WEINSTEIN: Sure.

COMMISSIONER ZUCKER: -- respond?

So a couple of things, one on the
maternal mortality. I remember your story
last year, and I have actually shared it with
others and have opportunity to share a story
also, not right now, but with you, about some
of these issues on maternal mortality.

The state is very, very committed to
this issue, as you know, and we will
continue. We're moving forward with the
issues of the review board and many of the
other challenges that we heard as a result of
the listening sessions that we did last year.

And the Governor is committed to this issue.
The department has been moving forward on
this. So rest assured that this is not
something which was just a series of meetings
and that we're not moving forward. We
continue to meet and we continue to implement
the charge that the Governor gave us.

On the issue of tobacco and
particularly vaping, this has been a
challenge. When we sat here last year, this
was not something which was even on the
radar. And we have, you know, 126 cases of
vaping-related illnesses in the State of
New York. Unfortunately, we've had four
deaths. And so the Governor has asked that
we take this on and address it, and we will,
to make sure that we do not create a next
generation of individuals addicted to
nicotine. So we'll move forward on that as
well.

CHAIRWOMAN WEINSTEIN: Thank you.

Senate.

CHAIRWOMAN KRUEGER: Thank you.

Our next questioner is Senator John
Liu.

SENATOR LIU: Thank you, Madam Chair.

Thank you, Commissioner, for joining
us today.

I do want to follow up a little bit on
the questions that my colleagues have asked
already, which is pertaining to the 3 percent
growth in Medicaid spending that now local
governments are going to be responsible for, according to the Governor's proposal. Is there already an idea which counties will likely exceed that 3 percent cap?

COMMISSIONER ZUCKER: We don't know that yet.

SENATOR LIU: You have no idea.

MEDICAID DIRECTOR FRESCATORE: No, I -- we don't -- I don't have that information.

Just as a clarification, counties that are within the property tax cap and within the 3 percent won't be picking up any additional funds. So the proposal as it's made is that if the locality grows their property tax by more than 2 percent, then they would pay the increase year to year in Medicaid costs.

But if the county, conversely, is within the property tax cap and within the 3 percent, which many counties will be, that there's a new opportunity in effect to share savings, which they don't have currently.

SENATOR LIU: What about counties that
don't have the 2 percent cap on property tax increases?

MEDICAID DIRECTOR FRESCATORE: The counties that don't -- whose tax cap -- taxes grow more than 2 percent would be responsible for the growth in Medicaid.

SENATOR LIU: And what's been the Medicaid growth in the last couple of years statewide?

MEDICAID DIRECTOR FRESCATORE: So the growth statewide for -- you know, if we look at year over year, has remained about 2.2 percent for a number of years running. In more recent years, more notably this past year, the increase in spending for a number of reasons that I think we've discussed, and we're happy to talk about here if it's of interest, has exceeded the global cap. But, you know --

SENATOR LIU: Has exceeded what? I'm sorry, has exceeded --

MEDICAID DIRECTOR FRESCATORE: Exceeded the 3 percent global cap. For a number of reasons, including --
SENATOR LIU: So last year the -- so
last year the growth exceeded 3 percent. And
the year before?

MEDICAID DIRECTOR FRESCATORE: It
would have -- I mean, it has varied from year
to year. On average, over the last several
years, it has been 2.2 percent growth year
over year.

In last state fiscal year, in order to
keep the spending within the 3 percent, which
is this 10-year rolling average of CPI, it
was necessary to take some administrative
actions to not exceed the cap. But generally
if we look since the MRT, the spending has
remained within the global cap in aggregate.

SENATOR LIU: So you're saying that
it's reasonable to expect that Medicaid, with
all these controls that will be implemented,
will be contained within a 3 percent growth
rate from this year to next year?

MEDICAID DIRECTOR FRESCATORE: We
believe that with the actions that are
proposed and the reconvening of the Medicaid
Redesign Team process, that just as we have
proven we've been able to do before, that we can find ways without impacting benefits or local governments to stay within the spending cap.

SENATOR LIU: So what can a local government -- give me an example of what a local government can do to contain their growth of Medicaid spending. This is in line with what our Assembly chairs already talked about.

MEDICAID DIRECTOR FRESCATORE: And so I've given some examples before --

SENATOR LIU: Just one.

MEDICAID DIRECTOR FRESCATORE: Well, I -- certainly, you know, some districts, for example --

SENATOR LIU: Deny benefits to people who need it?

MEDICAID DIRECTOR FRESCATORE: No. No. That would not be on our list. But we don't think it would be on theirs.

SENATOR LIU: Well, give us an example. What could a local government --

MEDICAID DIRECTOR FRESCATORE: So I
provided two examples before, I'll just say
them both again, which -- Senator, we know
that some local districts have found ways to
better identify assets or resources that
individuals have when they apply. That is a
good -- that's good program integrity, that
is good administration of the program.

And we also know that there are some
districts who have found, you know, and work
at very innovative ways to develop care plans
that are very, you know, efficient for
consumers when the local district is
responsible for the care. So we --

SENATOR LIU: So go after assets.

MEDICAID DIRECTOR FRESCATORE: Pardon

me?

SENATOR LIU: Go after assets.

MEDICAID DIRECTOR FRESCATORE: No.

Just be certain that any resource or asset
that should be counted in the Medicaid
application is identified. Not go after
assets.

But the population for which the local
districts make determinations generally have
both resource tests and look-back tests in certain instances.

SENATOR LIU: All right, thank you. In my final time, let me ask the commissioner about how the state is staying ahead of the curve on the novel coronavirus.

COMMISSIONER ZUCKER: Sure.

SENATOR LIU: You state in your testimony that we're ahead, that in fact your department identified this as a potential coronavirus while the rest of the world was still terming it some kind of mysterious disease.

COMMISSIONER ZUCKER: Well, we -- first of all, we have -- I will say that we have an incredible lab, the Wadsworth Lab, and the ability to identify and figure out problems ahead of time. That's in the big picture.

How are we staying ahead? We -- initially when this was a handful of cases that were reported in the news from Wuhan, we were -- already internally said there is the potential that this could spread. We jumped
on this immediately to figure out what we need to do, knowing that New York is an international center, both downstate and upstate. And we realized that we need to figure out what we would need to do.

SENATOR LIU: And what should New Yorkers do? Because there have been so many events that have already been canceled. What should New Yorkers do? Should they stay home?

COMMISSIONER ZUCKER: Well, I think the number-one thing to do is use really good common sense. You know, if you're sick, stay home, as you would do if you had the flu. I would not recommend anyone with a flu or a cold expose others to that potential virus that they have, whether it's coronavirus that's the one from Wuhan or a coronavirus that gives you a cold or a flu that we have in the -- this season.

I will say that we have had 58,000 cases of flu in the State of New York so far this year -- 57,000, 58,000. We will give you the same recommendations about
coronavirus that we give about flu, is that
if you're ill, call your doctor. You know,
limit your exposure to other individuals.

We're learning a lot about this virus
right now, and it's -- there is a lot of
information out there, unfortunately and
fortunately. Unfortunately, the power of the
internet is -- has an advantage because you
get information out quickly, and it has a
disadvantage because misinformation can also
get out.

So my advice to everyone is to use
good common sense, and if you -- wash your
hands and do all the same things that we tell
everyone to do when it comes to a cold or flu
season.

Right now there are over 5,000 cases
in China, there are five cases here in the
United States. We are tracking this. New
York State has had 11 persons of interest;
seven of them have come back negative. We're
still waiting to hear about the other four.
We have put signs and posters out there.
We're working with the Port Authority,
working with the MTA down in the city. We
are working with our hospital associations
and nursing associations, the physicians.
And we're on the forefront of this. And we
will -- like we do with every other issue, we
will tackle this. We tackled this when it
came to the measles outbreak, we tackled this
when it came to flu, vaping issues, and I can
go down the list of so many other things that
we've had over the course of at least during
my time in this seat. And we will do it
again. New York State always leads, and we
will lead on this.

SENATOR LIU: Thank you for staying on
the forefront.

CHAIRWOMAN KRUEGER: Thank you. No,
sorry, Senator, we're going to cut you off.
Thank you for the PSA on public health
practice --

(Laughter.)

CHAIRWOMAN KRUEGER: -- for new
viruses we may or may not be facing here at
home.

The Assembly.
CHAIRWOMAN WEINSTEIN: We go to
Assemblyman Cahill, chair of our Insurance
Committee.

ASSEMBLYMAN CAHILL: Thank you.

Dr. Zucker, your wonderful uplifting opening
about measles and vaping deaths and
coronavirus and Zika and Ebola and hepatitis
and contaminated water and cancer makes me
know why you were here early. You are the
only person for whom a joint legislative
hearing is the best part of your year.

(Laughter.)

ASSEMBLYMAN CAHILL: So I want to talk
to you about early childhood intervention.
But before I do, I just have a suggestion on
the MRT front. We heard the Governor's
speech and, you know, using just reductive
logic of where we're going to find our
savings with healthcare and particularly
Medicaid, he said it's not going to be the
beneficiaries, it's not going to be the
localities. That only leaves a couple of
places left.

I think it would be beneficial if
before even the panel was fully convened, if
the range of options were talked about
publicly so that there could be a real
serious public discussion about what is and
is not possible.

On to the area of early childhood
intervention. Is the state still using a
fiscal agent?

COMMISSIONER ZUCKER: We have a fiscal
agent. And I know there's concerns, but they
have been effective in what they're doing.
And I know we've had this conversation a
little bit about this.

ASSEMBLYMAN CAHILL: Yeah, we've had
this conversation, and also with -- I think
maybe even with your predecessors, over the
fiscal agent, because it's been going on for
over five years. And to my recollection, the
participation of insurance companies has not
increased over the course of that time, and
several tens of millions of dollars have been
given to the fiscal agent to make that
happen.

Is there still a bonusing structure in
place for the fiscal agent?

COMMISSIONER ZUCKER: I have to check on that.

ASSEMBLYMAN CAHILL: Okay, if you can get back to me on that, I'd appreciate it.

Under the new proposal that the Governor has offered, pay and pursue, what will the role of the fiscal agent be?

COMMISSIONER ZUCKER: Well, on the new proposals there's issues of billing codes, which you've heard, about trying to make the billing codes tighter and make sure the EI providers can consolidate those codes. So that's one issue.

There are other issues regarding written orders for the EI evaluations and therapy services, which is also helpful. And there's also we'll try to allow more therapists, we'll try to make sure that some of the plans that don't have therapists for Early Intervention will. That will be sort of something which we'll incorporate into that.

The tie of -- how this ties back to
the fiscal agents, you know, I can get back
to you on the details. But this is a
partnership in trying to move this forward,
and I know there's been concerns of why --
the role of the fiscal agent on this as well.

But we have collected, they have
collected a lot more than --

ASSEMBLYMAN CAHILL: That's not what
the statistics seem to prove. The statistics
seem to prove we're kind of stuck in the same
single-digit, low-single-digit recovery from
insurance companies that we were in before we
paid them 40, 50, 60, 70 million dollars.

Again, there's a proposal to continue
this sort of three-way division of
responsibility or four-way division of
responsibility. There's the fiscal agent has
some responsibility, the insurance companies
have some responsibilities, local and state
government have some responsibilities. But
still a significant burden is being placed on
the shoulders of folks who are making maybe
$25 an hour for providing services to the
most vulnerable kids in our population. And
they're not being compensated for their time when it comes to collecting their just compensation.

Isn't there a better way? Isn't there a way where we can say, okay, here's what the insurance companies are really responsible for, here's what we are responsible for, and just come up with a means of saying, you know, Okay, insurance companies, write us a check for this amount of money so we can fill the hole in the budget, get rid of this fiscal agent person, and save a couple of tens of millions of dollars there and let providers provide the services that they're intended to provide?

COMMISSIONER ZUCKER: Well, on one of the issues of the provider, one of the proposals is also to have the provider get paid from the insurer and then the insurer have to try to appeal to get the money back from them, right, so that they can at least get --

ASSEMBLYMAN CAHILL: And I get that. But I'm a little concerned with a provider
not making a lot of money -- a lot of single
moms in this business -- then finding out two
months later that the payment that the
insurance company gave them, they have to
give back. I mean, they probably already
paid the rent or the car payment or the water
bill with that money. So I don't know how
this fixes the problem.

COMMISSIONER ZUCKER: Right. But
hopefully the recognition is that they are
not going to get that -- the provider will
maintain that money and the insurance company
will not -- or the insurer will not be able
to pull that back.

ASSEMBLYMAN CAHILL: But that's
hopefully. That's not realistic. Because,
you know, if it's not a covered benefit and
the benefit has been paid for, the insurance
company will rightly recover it.

I won't dwell on this any longer, but
I would suggest that we seriously consider
revamping this system from soup to nuts. I
think the time has come. I think the
experiment with the fiscal agent has proven
to be a failure and it's time for us to
really get our arms around this so that we
can get back to the provision of services for
children as being the focus of this program.

COMMISSIONER ZUCKER: You know, I know
you're out of time, but I will just say that
when I was preparing, looking at some of the
materials, I was also saying to myself maybe
at some point we could just sit down, not in
this forum, and just hash out some of these
challenges. You know, a handful of us -- my
experts on the team and your team -- to go
through it.

That would be helpful, and I'll be
involved in that. Thanks.

CHAIRWOMAN WEINSTEIN: Thank you.
We've been joined by Assemblyman
McDonald.

And now to the Senate.

CHAIRWOMAN KRUEGER: Thank you.
We've been joined by Anna Kaplan, and our next questioner is Todd Kaminsky.

SENATOR KAMINSKY: Hello, Doctor.

COMMISSIONER ZUCKER: How are you?

SENATOR KAMINSKY: I'd like to ask you a question about the Supplemental Food Assistance Program. Right now on Long Island there is a gap with the program that's incredibly important to many people -- 50,000 Long Islanders are supposed to receive supplemental food assistance and, because of the way the bidding process was, there's right now no -- there's no person that is meant or no organization that is meant to serve those individuals.

Now, while a stopgap measure was put in place, which is appreciated, that's due to expire the end of March, and right now there's no provision to have more supplemental food, which our seniors, especially, and families rely on.

So I'd like to read you a letter I received from a woman named Barbara at the Long Beach Housing Authority, which I think
really gets at the issue. Barbara writes:

"I've been getting meals from this program
for the past eight years. I get meals two or
three times a month, and it was good food.
I'd get cereal and milk -- the really good
kind of milk, too -- sometimes chicken or
fish, and I just had to stick them in the
microwave. A lot of seniors in my building
do not get food stamps, and they're
struggling to get food. The seniors that do
get food stamps get about $16 a month, and it
is not enough to buy food. We relied heavily
on this program, and now it has been taken
from us and we get nothing. The state needs
to do something and to help seniors."

I have many such letters, and I have
trouble believing that our state, in light of
being in the wealthiest country in the world,
in a wealthy state with a budget in the tens
of billions of dollars, well north of
$100 billion, that we're not able to do
something to guarantee that 50,000
Long Islanders who until recently received
supplemental food assistance, can't still get
it. And I'm hoping we could fix that.

COMMISSIONER ZUCKER: So let me address that.

And first I agree with you, the state is committed to the aging population. We are the first age-friendly state in the nation. As you probably have heard me say, that this is one of the issues that I have asked the department to work heavily on regarding the needs of the seniors in the State of New York.

DOH has funded and has executed two emergency contracts to transition seniors to other food service -- food access programs on Long Island, so we're working on that as well. We did extend the contract initially on that issue.

We're also working for a longer-term plan for this issue. We're working with our partners like SOFA to explore what other options are there.

I recognize the concerns, and I assure you that we will do everything to make sure that food and nutrition is available to
those -- whether it's through this kind of
program or another program that will help
them. So I hear what you say, I hear the
words of your constituent, as well as others
who have spoken about this.

SENATOR KAMINSKY: Can I tell the
seniors that I'm talking to that by April 1
of this year there will be the same
supplemental food that they've been relying
on?

COMMISSIONER ZUCKER: I'm going to
work -- well, I don't want to commit to that
particular contract or plan, but we will work
to make sure that there is -- the needs --
their needs are met. I think that's about
what --

SENATOR KAMINSKY: You can understand
it's a very difficult conversation to tell
someone that because the RFP process went
screwy, there's no provider here, so we'll
figure it out. I mean, this is -- this is
very critical. So I really am counting on
your partnership in getting this done in the
budget this year.
COMMISSIONER ZUCKER: I hear you. I hear that from their perspective there's a bureaucracy of -- sort of that didn't work and someone didn't fill something out on their end, and that we could not say something ahead of time because that's not within the way the laws are written of what we're allowed to say and we had to wait until we issued a contract to somebody.

But all that said, there's somebody on the other end of this who needs their food, and we will make sure that happens.

SENATOR KAMINSKY: Thank you.

I'd like to ask you about the study to provide New York City water to Nassau County. It's mentioned very descriptively, but then there's -- I don't see and there's not money actually funded for it in the budget.

Can you tell us if that money is going to be available, how much you think it is, and are you committed to seeing it through?

COMMISSIONER ZUCKER: So I can't give you the amount -- you know, how much money will be allocated to this. However, I will
tell you that DOH and DEC are working on
this. We recognize the interests of making
sure that there is water, the potentially
city water system goes out to Long Island.

The Governor has committed an
incredible amount of resources, in the
billions, for issues of drinking water
quality. We have a task force that is
chaired between Basil Seggos and myself. We
have been working on so many different areas,
whether it's 140-something different water
systems that we have addressed. I think that
this nation leads on this issue, and we will
lead on this as well. And I would challenge
anyone to tell me of any other state in this
nation that has not committed so much to the
issues of environment and water quality as we
have in the state under the Governor's
leadership.

SENATOR KAMINSKY: I appreciate that.

Lastly, what do you say to some CPA
firms who have been told they can no longer
certify cost reports and that the work will
be audited by KPMG on the back end? Many of
them have hired staff, they're ready to do them, and they've just been told it's done.

Is there going to be any process for addressing that?

MEDICAID DIRECTOR FRESCATORE: Yeah, and we -- thank you. We became aware of this concern I think just yesterday.

So we have developed a new cost report consistent with state law that was enacted for broadly home care providers, and in being -- attempting to be flexible and recognize, you know, the new cost reporting structure and the administrative requirements on the agencies, we removed the requirement that the cost report be certified by a CPA. This is the case currently with other reports, including the hospital cost reports.

We didn't in any way intend to say to an agency that a CPA shouldn't or can't help them prepare it or submit it on their behalf. It was just a matter of having, you know, a separate certification.

We can clarify that if you think that is helpful. And, you know, certainly
providers -- we want to give them the
flexibility to decide whether or not they
want that review done, even if it's not a
formal certification.

SENATOR KAMINSKY: Thank you.

CHAIRWOMAN KRUEGER: Assembly.

CHAIRWOMAN WEINSTEIN: We have been
joined by Assemblywoman Byrnes, Assemblywoman
Rosenthal. And we go to Assemblyman Byrne
for questions.

ASSEMBLYMAN BYRNE: Thank you,
Chairwoman. And thank you, Commissioner,
Dr. Zucker. And Director Frescatore, I want
to say thank you again for being here.

At the risk of being a little
redundant, I'm going to ask some questions
that are probably a little bit familiar to
what you've already heard from my colleagues.
And I know we're limited on time, so I'm
going to try to ask a few questions and then
give you some time to respond, if that's okay
with you.

My first question is, how are we in
this mess with the budget deficit? Because
when we were talking about the deficit early on, reports were pointing to things like increased costs for long-term care, the minimum wage. And then more recently we're hearing about things like local governments. And I'd like to really drill down on why did we get -- why has the cost of the program grown. So what are we looking at specifically? And when did we learn about that? And when was that shared with the Legislature, and why not sooner? Because one question I'm eager to ask directly more to you, Commissioner, is my understanding is with the global cap, when that passed initially, you do have some additional powers to implement cost-cutting plans -- to see what your thought process was and why you did not do that. And then that's really more why we're here with this deficit. I'd like to hear your thoughts.

The MRT II plan, just to echo what my colleagues have already said, certainly transparency is a must. I would add balance. People mentioned -- my colleagues mentioned
emergency service providers, EMS. Certainly
I would say all stakeholders, all providers,
home care, deserve a seat at that table.
And I would say the Legislature
deserves a seat at the table too. I believe
the last time majority/minority conferences
had some appointments. I would strongly urge
that we have a presence there, because I know
we'd like to talk in more detail. At this
hearing, it's a budget hearing. That at a
minimum, we should be present at the MRT II
as well.

And then finally, I did want to -- and
Commissioner, this may be a question that you
may end up referring to OASAS for another
public hearing later, but I still want to
bring it up. Because I believe last year we
passed the -- that opioid sales tax brings in
revenue to the state. And there's a growing
need for things like medication-assisted
treatment and access for MAT. And the
Governor did veto a bill earlier that would
have eliminated preauthorization for Medicaid
services. He didn't veto one for, I believe,
private plans.

But he says he wants to expand MAT and make that a priority. Well, how much money are we expanding for those services? And that $100 million we're getting from the opioid tax, is it going to help the people that are suffering from addiction?

So I'll close with that, and then maybe I'll follow up if there's time.

COMMISSIONER ZUCKER: Sure, let me see if I can address some of this.

So I'm going to start on the issue of your first question about how did we get here. And I just wanted to share some numbers. So when the Governor came in in 2011, we were at 13 percent Medicaid spending. It was growing truly at an unsustainable rate.

And since 2012, so just going from there, one and a half million New Yorkers have gained Medicaid. So that's a 32 percent increase in Medicaid enrollment. We went from 4.7 to 6.2 million people.

At the same time, the rate of
uninsured New Yorkers has declined. We are
-- right now we have 18 million people
covered. That's 95 percent, essentially
95 percent of the state. That's
unbelievable. That's excellent. All Funds
Medicaid spending has grown substantially
over the same period. So we went from
54 billion in 2012 to 77 billion. So that
was 2012 to 2020.

And now we're a decade later. Many
things have changed, as I mentioned a little
bit about the long-term care issues, the
costs, the aging population, many other
things. We've been challenged.

So overall healthcare costs have
increased, managed long-term care has gone
up. This increased minimum wage is another
issue that comes into play here. These are
just some of the things that we've had --

ASSEMBLYMAN BYRNE: So I'm sorry to
interrupt, only because I want you to
continue to answer the question. But so it
would be unfair, in your opinion, to point
this solely at local governments? You would
look at it as a totality of --

COMMISSIONER ZUCKER: There's multiple, there's many factors.

ASSEMBLYMAN BYRNE: Okay, continue,

I'm sorry.

COMMISSIONER ZUCKER: I was going to say local takeover, enrollment, there are many different issues that are involved here, and Donna can go through the details on all of this as well on some of the different parts here.

So this is a change in the landscape. We, as I've mentioned, we will tackle it. We've done it before. And that's why when you ask about MRT II, we need to be sure that all the individual stakeholders are involved. The Legislature of course will be involved, that they were involved in the MRT -- the first one. And home care obviously are some of the things that have changed, because people are moving from the hospital into home care, and it was different in 2011-2012. So that's one issue.

Donna, do you want to add to that, and
then I can get back to the MRT.

MEDICAID DIRECTOR FRESCATORE: Yeah, I think, Dr. Zucker, you covered all the major points. We know that healthcare costs are increasing more than the 3 percent allowance in the global cap. In fact, the CMS office of the actuary specific to Medicaid estimates the cost growth nationally at about 5.5 percent.

So the cap, a very important tool. And that's exactly what it is, in my view. It's a tool for us all to monitor spending. The reality of -- the amount of money we have to spend is the reality. The global cap, to me, is a tool by which we -- the metric by which we all measure it. And certainly something could be discussed in the MRT process.

Managed long-term care has put a tremendous amount of pressure -- with aging demographics, we've seen a 301 percent increase in the cost of the managed long-term care program between 2013 and 2019. It now accounts for 33 percent of total Medicaid
spending, just the managed long-term care program.

Certainly the Medicaid cost of paying minimum wage to healthcare workers has added to spending. Thus far, the Medicaid global cap has supported about $2.4 billion of costs. We would argue very, very good policy, but it does result in spending. We expect that will grow to $1.8 billion in the current year.

The enrollment, as Dr. Zucker mentioned -- remember, the cap is aggregate, it's not a per-person cap, so it absorbs changes in enrollment. We had a tremendous, you know, ability to reach people who were already eligible for Medicaid, in large part, but had not signed up. And so that put pressure on the cap.

Certainly the policy decision to freeze local contribution -- the Medicaid global spending cap is looking at the state spending, the state Department of Health spending only -- contributed to the structural deficit in the cap.
And then additionally and importantly, from our perspective, support for distressed hospitals, through operating assistance that totals probably about $800 million a year that counts towards the cap.

You know, I think all kind of a long way of saying that these things came together. And in March of last year -- we had been watching the trends through the fall. In March of last year we realized that certain anticipated things weren't going to happen, that the growth in managed long-term care was going to be sustained, that it wasn't kind of a one-time increase.

We also were not able, due to various reasons, including delays in federal approval, to implement some of the savings options that had been enacted in prior years' budgets. And we needed to take an action. And with the administrative authority of the commissioners, we looked at a range of different options and concluded that the option that would result in the least disruption -- I would argue virtually no
disruption -- to consumers or their access or
quality of care, would be to defer by three
days a last cycle of payment to the managed
care plans. And that was about -- that was
the majority of the $1.7 billion deferral --

ASSEMBLYMAN BYRNE: Into the next
fiscal year.

CHAIRWOMAN KRUEGER: We're going to
cut you off, sorry, since the time has been
up for a while. Thank you.

We've been joined by Senator Biaggi,
and our next questioner is Senator Brad
Hoylman.

SENATOR HOYLMAN: Good to see you,
Doctor -- Commissioner. I never know what to
call you, Doctor or Commissioner. How about
Dr. Commissioner?

I wanted to ask two general sets of
questions. The first is about your work on
vaping and flavors; I appreciate that. As
you know, the FDA came out with a directive
that I would imagine you would agree is
insufficient because it has nothing about
open-tank system or disposable vape products,
many of which are flavors. I'm looking at a list of them here, flavors like Cherry Crush, Pomegranate, Watermelon Ice -- all of those flavors that some of the vaping companies like JUUL have voluntarily stopped selling.

Are you seeing an increase in disposable vaping products? I've heard this from my constituent parents who have children who are middle schoolers and high schoolers, and they've switched from products like JUUL to products like VGOD, blu, MOJO, NJOY, XPod, Posh, Element that, one, use disposables.

COMMISSIONER ZUCKER: I have to find out the answer to that question. I've heard that people are using these disposables, but whether an increase or not, I'll find out. I'm not sure.

SENATOR HOYLMAIN: Secondly on that issue, what would you tell my colleagues who I think are rightly concerned that if we do pass legislation to ban flavored e-cigarette products, that it might increase black market use? In fact, that's what Donald Trump said, no less an authority than Donald Trump.
COMMISSIONER ZUCKER: So I think that
the challenge here is that we have recognized
in the past the amount of the dangers of
having kids get addicted, and I think we need
to make all efforts to prevent that from
happening. We need to tackle this as -- the
way we're doing, the Governor's budget
proposals, with all the different issues we
mentioned: Banning the flavored nicotine
products and prohibiting the sale of tobacco
products, including e-cigarettes, to all
youth, and the advertising issues, to get rid
of these advertising of vaping-related
products, and many other things that we're
tackling here on this, whether it's banning
certain carrier oils, all of that.
I think in response to your specific
question whether this will go underground, I
can't say a hundred percent for sure. But we
will work to prevent that from happening as
well. I think -- I have a lot of faith in
our youth that if we educate them, if we
provide them with information, that they will
recognize the dangers that could befall them
if they start to use products that are unsafe
for them. And I think that if we explain
that if you get this product from the black
market or something of that nature, it's
still dangerous to you and you can get pretty
seriously injured.

SENATOR HOYLMAN: Well, thank you.
And I hope we can address this even before,
you know, the budget is completed, because as
you know, there were two deaths recently.
And every day, I think, with these products
on the market is dangerous --

COMMISSIONER ZUCKER: I agree.

SENATOR HOYLMAN: -- for New Yorkers
and especially children, as you have pointed
out repeatedly, which again I appreciate.

Very quickly on a local issue, there
is a senior residence in my district that I
share with Assemblywoman Rosenthal called
Riverview Independent Senior Living. They
announced recently, with no warning to
tenants, that they'd be selling the building
and closing the facility within months. That
left many of the elderly tenants, including a
99-year-old Holocaust survivor, worrying about where they would live next.

They don't appear in DOH's registry of licensed assisted-living services because they skirt the regulations. But they offer this wide array of services to seniors that would seem to place them within the department's purview, such as meals, housekeeping, laundry services, emergency alert buttons, 24-hour security, maintenance, transportation, visiting medical professionals.

Do you think that their operating model, that Riverview's operating model is one that should require examination for licensure or regulation by the Department of Health?

COMMISSIONER ZUCKER: Let me see if I understand your question. You're asking whether we feel that the models that we have in place address the needs of seniors in some of these long-term care or facilities is the right model that we have? Is that --

SENATOR HOYLMAN: Exactly. In other
words, this independent living facility provides services to seniors, but they're not regulated by the Department of Health.

COMMISSIONER ZUCKER: So that's a great question. I think this is where the whole issue of the aging population in the state and how we provide services to them needs to continually be addressed and modified accordingly, because as I mentioned before, the population of those who are seniors in the state is increasing, and the support they need increases as well, particularly when you're talking 99, 95 -- it's a lot different than 75. And so I think we just have to adjust.

And the Governor, as I said, is committed to the issues of the aging. I know our team in the department have been working on this with both the long-term-care facilities, home care. I've had them in my office multiple times looking at what else we could do to provide care for those who are caregivers, how we can remove some of the issues of some of the challenges including
depression among those who are lonely. We're working with the Office of Mental Health on that issue.

And so all these issues come into play, and I think that, you know, what's our role in regulating this or what's our role in addressing it, I think that we need to take another look at it and see what we can do. I don't want to add, you know, another challenge for those in the community or regulate another area, but whatever is best for those who are elderly, we will do as a state.

SENATOR HOYLMAN: Thank you very much.

CHAIRWOMAN KRUEGER: Thank you.

Assembly.

CHAIRWOMAN WEINSTEIN: We've been joined by Assemblyman Blake, Assemblywoman Gunther. And we go to Assemblyman Garbarino for questions.

ASSEMBLYMAN GARBARINO: Thank you. Director, Commissioner, nice to see you.

I just want to get back to the MRT
real quick. I know you confirmed before that
the Legislature is going to have
appointments. I know this has at least been
eight days since the Governor announced that
it was going to happen. So I know you don't
know who the people are yet, but I would
expect that you would know what agencies or
what groups would have spots. Can you
confirm whether or not the health plans will
have somebody on? The health plans, anybody
from them?

COMMISSIONER ZUCKER: I don't have the
answers on all of that yet, but we'll be
happy to get back to you about which aspects
of the Legislature, the stakeholders and all
of that. But we will get that to you as soon
as we can.

ASSEMBLYMAN GARBARINO: I know you
don't know the people, you don't even know
who's -- what -- what agencies you're looking
at or what departments or --

COMMISSIONER ZUCKER: Not yet. And I
know you're saying it's been eight days, but
the fact is that everyone's been working on
this, and I will -- I'll get back to you on that.

ASSEMBLYMAN GARBARINO: I want to go back to -- also in the State of the State the Governor said that -- no new taxes. But the budget director did not rule out taxes on health plans -- on health plans, I believe, in a press conference.

So it's a little confusing. Are new taxes off the table or on the table?

COMMISSIONER ZUCKER: I guess that's a question back for the budget team, and I'll have to ask, you know, Mr. Mujica on some of the questions that were raised.

But if the Governor said no new taxes, then there's no new taxes.

ASSEMBLYMAN GARBARINO: Okay. We just had recent -- in December -- 1 percent cuts on Medicaid rates, I believe, went into effect. Administrative cuts, Medicaid, 1 percent in December. Has Deloitte certified that those new rates are actuarially sound?

MEDICAID DIRECTOR FRESCATORE: Yeah,
the -- I think you're referring to there's appropriation authority in the enacted budget --

ASSEMBLYMAN GARBARINO: Yup.

MEDICAID DIRECTOR FRESCATORE: -- to allow for up to $190 million in across-the-board cuts.

The total for this fiscal year in across the board was 62 million. So, you know, far shy -- we were able to figure that out, so far shy of 190 million. Of that, the healthcare plans, because they're about a $48 billion spend, actually are allocated about 41 of the 62.

As always, when we change premium rates, we are required under federal rules to have independent actuaries certify the actuarial soundness of the rate. And that was in fact done by Deloitte, because they are our contracted actuary.

ASSEMBLYMAN GARBARINO: Is there a report or --

MEDICAID DIRECTOR FRESCATORE: They don't typically issue a report for each of
the actions. As you might know, these
premium rates can change many times during
the year, often the result of enactment of
legislative program changes or legislative
directives.

ASSEMBLYMAN GARBARINO: Aren't they
required to share their findings with the
health plans, under law?

MEDICAID DIRECTOR FRESCATORE: We are
required to -- they are required to make a
certification. We can look and see how
detailed that report is. But we would not
advance rates -- you know, as you may know,
there's an actuarial soundness range in which
the rates must fall, and that's the
certification, is that a premium rate would
fall within that acceptable range, which
is --

ASSEMBLYMAN GARBARINO: But the new
rates, the 1 percent, they've been --

MEDICAID DIRECTOR FRESCATORE: Pardon
me?

ASSEMBLYMAN GARBARINO: Have they been
certified, the new rates, after the 1 percent
cut?

MEDICAID DIRECTOR FRESCATORE: Yes.

ASSEMBLYMAN GARBARINO: Okay. You
mentioned before about going after assets as
a tool that the counties could do with --
under the state -- under the 3 percent for
Medicaid growth. Are you suggesting counties
should possibly file liens on people's
properties or go after spousal refusal or
something like that?

MEDICAID DIRECTOR FRESCATORE: Yeah,
Assemblyman, just for clarification, I think
I was asked whether or not that was the
suggestion, to go after assets. And the
answer to that was no, that's not
specifically -- I should, you know, probably
say that we believe that the local
districts -- and again, we intend this to be
a partnership. The local districts are on
the ground, they know their districts really
well. And they know their Medicaid program
locally. And it's been a partnership of
developing initiatives in partnership with
them, not dictating a list from the
Department of Health to the local districts.

What I was mentioning is that over

time, and you might remember some years ago

there were local demonstration projects, they
go probably back many, many years. And some
districts have found, for example, that they
can -- they use databases, data sources when

someone is applying that they review or look
at to be able to test to see if there are

other resources that are available that would

factor into the initial eligibility
determination.

ASSEMBLYMAN GARBARINO: Like spousal

refusal, but right now a spouse can refuse

the support --

MEDICAID DIRECTOR FRESCATORE: Well,

that we all -- we all -- not necessarily

spousal refusal. I mean, we would expect the
districts, just as when we make our
determinations, would follow whatever the

existing federal and state law is.

ASSEMBLYMAN GARBARINO: Okay. Just

one last question, and going back to tobacco.

There's something that prohibits the display
of tobacco products and vaping in stores. We
couldn't find it, I don't think, in the
language. Is there an exemption for actual
tobacco stores or vaping stores that are
specifically, you know, just for that?

COMMISSIONER ZUCKER: I'm not sure
about that. I'll have to get back to you
with any exception.

ASSEMBLYMAN GARBARINO: Should there
be? I mean, you don't want to walk into a
store with empty shelves.

COMMISSIONER ZUCKER: Well, tobacco --
I mean, the rule is that if it's a vaping
store, then they could sell product. We
don't want flavored product sold. But I'm
not going to -- I don't want tobacco sold
in --

ASSEMBLYMAN GARBARINO: I understand
that.

CHAIRWOMAN WEINSTEIN: Thank you.

To the Senate.

CHAIRWOMAN KRUEGER: Thank you.

Senator Gallivan, the ranking member on
Health.
SENATOR GALLIVAN: Thank you, Madam Chair.

Can you tell me, how much does the state spend on Medicaid?

MEDICAID DIRECTOR FRESCATORE: I'm sorry, how much does the state spend on Medicaid? The global -- the global cap number for this year is -- let me get that for you exactly -- 23.6 billion --

CHAIRWOMAN WEINSTEIN: Can you put the mic a little closer to you?

MEDICAID DIRECTOR FRESCATORE: Yeah, I don't want to rustle papers here and be distracted. Let me get you that exact number, which is the global cap calculation from the State Financial Plan.

It is, for this current year, for 2020, the state calculation is 22.3 billion, that's state share spending. And for 2021, the projected spending under the global cap is 23.6 billion.

SENATOR GALLIVAN: This upcoming year, what is that number again?

MEDICAID DIRECTOR FRESCATORE:
Twenty-three-point-six billion.

SENATOR GALLIVAN: So that's global cap, right?

MEDICAID DIRECTOR FRESCATORE: That's the state spending, DOH state spending, that's right.

SENATOR GALLIVAN: Okay. What other Medicaid spending is there? There's Medicaid spending that's exempted from the cap.

MEDICAID DIRECTOR FRESCATORE: There are some -- there is some spending, I don't have that detail here, we can get that for you, that would not be under the global cap under the way the cap is currently structured.

SENATOR GALLIVAN: You don't know that?

MEDICAID DIRECTOR FRESCATORE: I don't have those exact numbers.

SENATOR GALLIVAN: I'm thinking it's around 6 billion, but I don't know for sure.

MEDICAID DIRECTOR FRESCATORE: Yeah, I don't have those exact numbers with me, and I don't want to missspeak there. I want to make
SENATOR GALLIVAN: Let's go back to the global cap. And I'm looking at the last report that just came out, the April through December 2019 report. And I've got close to $193 million, I think it is, that's actually non-Medicaid spending that's funded by the Medicaid global cap -- non-Medicaid programs. So some supportive housing, Alzheimer's caregiver support, among other things.

I don't need to get in all the exact dollars, I just -- but you know what I'm talking about?

MEDICAID DIRECTOR FRESCATORE: There are some -- there's --

SENATOR GALLIVAN: Non-Medicaid programs funded out of the Medicaid global cap, where we are not getting federal dollars for it.

MEDICAID DIRECTOR FRESCATORE: Yeah, I mean there's a number of -- there's spending that's state-only for a variety of reasons. There are some programs that have a Medicaid allocation that currently counts against the
Medicaid spending cap.

SENATOR GALLIVAN: So my question would be, though, given this deficit that we have, this seeming elusive number, wherever the actual number is, the point remains the same. Why would we include non-federal Medicaid spending under the Medicaid global cap when we can't get reimbursement for it? Wouldn't that be better placed under the general operating budget and then you could shift things that we could get reimbursed, there could be a federal match for under the global cap?

MEDICAID DIRECTOR FRESCATORE: Well, I think it would be helpful -- I mean, we can certainly, you know, talk about specifics and talk along with the Division of the Budget, but there are a number -- there's different spending categories under the global cap that do not have a federal share. And we can certainly talk about the ones that you're -- that, you know, you might have specific questions about.

SENATOR GALLIVAN: Okay. There's more
discussion to follow, but for the sake of time, if we could move on. Statewide Healthcare Facility Transformation Program capital. In fiscal year '19 we allocated an additional $425 million for our hospitals and their various needs. And there hasn't been any requests for application that's sent out yet; I'm wondering when that's going to take place.

COMMISSIONER ZUCKER: We'll check on that. For the capital -- the most -- the next round of capital for hospitals?

SENATOR GALLIVAN: Yes.

COMMISSIONER ZUCKER: So that's No. 3 that we're talking about.

SENATOR GALLIVAN: It is No. 3, yes.

COMMISSIONER ZUCKER: Yes, and I will get you the information as to when. We put out a lot of resources, obviously, to -- on the previous capital grants to the hospitals, and they have been helpful and successful to improve hospitals across the state.

SENATOR GALLIVAN: Very helpful and successful for the hospitals. But as you
know, it's tough to run a hospital whether
it's in the City of -- the biggest one in the
City of New York or the smallest, most rural
one.

COMMISSIONER ZUCKER: I agree. And --

SENATOR GALLIVAN: And we work hard to
put -- we work hard to come up with the money
to put in place for a program, and now they
just sit there and they're waiting and
waiting and waiting, and we promise. And
we're waiting on you.

COMMISSIONER ZUCKER: I know we've
given out the capital that has been provided
to the hospitals. All of those have been --
the last rounds --

SENATOR GALLIVAN: The last rounds, I
know.

COMMISSIONER ZUCKER: -- right, have
been provided to those facilities. And we
will go to the third round as well. And I'll
get you the --

SENATOR GALLIVAN: Could you please
let us know?

COMMISSIONER ZUCKER: I'll get you the
data on that as well.

SENATOR GALLIVAN: Thank you.

COMMISSIONER ZUCKER: Sure.

CHAIRWOMAN WEINSTEIN: We go to

Assemblyman Sayegh.

ASSEMBLYMAN SAYEGH: Thank you very

much, Commissioner Zucker, Director

Frescatore. A couple of quick questions.

Over the last number of years -- and

this is really a general question involved in

primary care solo medical practices. The

trend the last 20 years -- not only in New

York, across the country -- has been to

really consolidate medical practices.

Therefore, many patients are concerned that,

similar to losing the mom-and-pop stores, the

old days where you had your local businesses

and the constituents or the customers or the

patients, in this case, really had a

one-to-one close relationship with medical

doctors. They feel that they're losing that

and that there isn't really enough effort to

really allow solo practitioners to really

even think about opening practices like in
the past. And many are being forced to join
groups or other arrangements, and patients
have lost that valuable service of knowing
their medical doctor and being able to go and
get treatment from that medical doctor.

And the second question, you know, we
recently last year passed bold vaccination
policy and procedures. We limited medical
exemptions to some extent. Medical doctors
for those children that are not attending
schools, that really feel there's a
legitimate concern for their health and
safety, in some cases may be qualified and
allowed to take or get medical exemptions.

What can we do to really keep that
practice alive? Whereas we got rid of
religious exemptions -- I'm not sure what the
number is, but they stated as high as 26,000
kids out of schools. So what can we do to at
least protect those children with medical
exemptions and make sure that the medical
profession doesn't look at it as a stigma?

COMMISSIONER ZUCKER: Sure. Thank
you. And thank you for those questions.
Let me start with the first one regarding primary care. So I wear two hats on this one; I wear the hat in the role as commissioner; I wear the hat as a doctor. And I will tell you that I have my primary care doctor, I like my solo practice primary care doctor, and I like sitting down and having a chance to speak with him about many different issues. And I feel for the physicians who are in solo practice feeling that -- as this whole change in how medicine is being practiced.

Part of it is that there are changes in the way healthcare is going. Part of it is that the asks that are being placed upon physicians is quite enormous, and in order to actually be able to continue to practice and balance all the competing interests, both professional and personal, it ends up that there are groups, and then ultimately what happens, sometimes hospitals bring those groups into their fold.

This is something which -- the role of the physician is something which I have been
thinking about a lot and in fact will be bringing together and working on this right now, a meeting with all of the different groups and physicians to address the future of the physician-patient relationship, the relationship between the physician and access to care and physicians in hospitals and technology.

So I hope I will be able to, either prior to the next time we are in a hearing like this, or separately in a meeting with you, to share some of what comes out of that discussion which will be coming in the spring.

That's one part, and I recognize that.

With regards to the second question on immunizations and the exemptions, we have had unprecedented success with preventing measles from spreading, not just in New York but in the nation. The -- it's really the school districts. When it comes to medical exemptions, if someone has a medical exemption, then we recognize that and respect that. But it is within the school system.
It's not the Department of Health that issues that, so it's within the school system.

We're happy to work with the school systems on that, but that's where it has to go, between the health professional -- doctor, nurse, practitioner -- to the school on that.

But I will say that there's been a lot of work on these issues, and I just feel that the benefits of immunizations and what we can do is one of the great public health achievements. But I do recognize the challenges of particular cases, specific cases where there is truly a medical exemption.

ASSEMBLYMAN SAYEGH: Thank you very much.

CHAIRWOMAN WEINSTEIN: Thank you. We go to Senator Myrie.

SENATOR MYRIE: Thank you both for your testimony.

I represent Central Brooklyn that, as you know, is in the throes of a black maternal morbidity and mortality crisis.
There are a number of social determinants that contribute to that as well, and I think it is in part the reason why the Governor a few years ago rolled out, to much fanfare, the One Brooklyn Health System.

My questions are going to be around the ICP and how it relates to that system insofar as us being ground zero for many of the contributors to the mortality crisis, and the impact that the distribution of ICP funds will have on the One Brooklyn Health System.

So it is my understanding that One Brooklyn Health has already, by way of the cuts in January, had a $3.8 million cut due to the 1 percent Medicaid reduction. It is my understanding that they are also absorbing the costs for the 1199 contract, to the tune of 16 to 18 million dollars. And the distribution formula as it currently stands for ICP funds disadvantages hospitals and systems like One Brooklyn Health that have a disproportionate Medicaid consumer population.

And so my question is, while there is
currently legislation by my colleague Senator Rivera that would redirect ICP funds to hospitals of the greatest need, I'm wondering if there is action that the Health Department could take right now in light of all of the things that I just mentioned.

COMMISSIONER ZUCKER: So let me -- the first part of this is that the One Brooklyn Health is one part of the bigger initiative Vital Brooklyn, which is the Governor's initiative to look at all the social determinants of health. And One Brooklyn Health is something we have moved forward, and I believe will actually, as I've said before in this room, be a model for healthcare reform for all urban areas across the country. So we're moving that forward.

On the specifics of the Medicaid and the $3 billion cut -- Donna, do you know about that amount?

MEDICAID DIRECTOR FRESCATORE: Yeah, I don't know -- I don't know -- have it provider specific. But it could offer those certainly, Senator. There's been a few
different actions that impact Medicaid

revenue to a particular facility, including
the trend, the 2 percent trend, the first
trend that had been done on the Medicaid
program I think since probably 2011. That
certainly has an upward impact. And then, as
you mentioned, the across-the-board --

CHAIRWOMAN WEINSTEIN: Excuse me,

Donna. We need you to really talk into the
mic, because it's not -- the acoustics are
just really not great in this room.

MEDICAID DIRECTOR FRESCATORE: You
can't hear up there? Okay. Sorry about
that. Apparently these don't come any
closer.

So there's a number of factors I think
that impact the Medicaid reimbursement to a
particular facility. We certainly can, you
know, talk offline about those in particular.

You mentioned the across-the-board,
which was pursuant to the appropriation
authority. In this budget you I think know
there was also a 2 percent across-the-board
increase, the first increase to hospitals I
think since 2011, so a very long time. And how things work together, we're happy to sit down and go over.

On the distribution, I think you all know that we met many times with a workgroup on the indigent care pools -- I should say what ICP is -- to talk about the current distribution formulas. We heard many, you know, comments, concerns about how the formulas currently work now, and we want to continue to have that dialogue over the course of the next weeks and months. We understand how critically important that funding is to the hospitals -- all hospitals, but in particular those who serve a large percentage of people who are Medicaid or self-pay.

SENATOR MYRIE: I appreciate that and would underscore how important that funding is.

And I imagine that there's not going to be a different answer here -- no matter how artfully or creatively we ask about the constitution and transparency of MRT II, I
don't believe we're going to get the answer
to that. But I will advocate for a
representative from our SUNY institutions and
also from our HHC institutions in the city.
I think it is critically important, with the
cuts that we are facing, particularly in
areas that I represent, and particularly on
the black maternal morbidity and mortality
crisis. I think it is critical that those
voices are elevated on any decisions that are
going to be made as it pertains to Medicaid
provision.

Thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

We go now to Assemblyman Braunstein.

ASSEMBLYMAN BRAUNSTEIN: Good morning.

My question is about the cost shifts
to the localities and how it interacts with
the 2 percent property tax cap.

So how would it work if a locality
doesn't comply with the 2 percent tax cap?
They have to take up the entire increase in
Medicaid, not just over 3 percent?

COMMISSIONER ZUCKER: It would be the
difference, the -- if the -- well, if they
don't meet the 2 percent property tax, then
they would pick up the cost. If the
Medicaid -- if they go over the 3 percent
spending, then they would pick up the
difference on that. So if they're over
2 percent property tax.

ASSEMBLYMAN BRAUNSTEIN: So how would
it work for the City of New York, right? The
City of New York is not subject to the 2
percent property tax cap. It's likely that
they're not going to comply another year with
the 2 percent tax cap. So do they pick up
just more than 3 percent of their increase in
Medicaid spending, or do they pick up the
entire increase in Medicaid spending?

COMMISSIONER ZUCKER: Well, there's
two parts. One is the 2 percent, and if they
go over that, they pick up the cost. With
the Medicaid, if they go over the 3 percent,
then they pay the difference on the Medicaid.

But did you want to --

MEDICAID DIRECTOR FRESCATORE: Yeah,
yeah. I think that, you know, it's probably
important to preface this with, you know,
some of the history here, which was that the
intention of taking over the growth in
Medicaid, the state taking it over, was to
relieve localities so that they could --

ASSEMBLYMAN BRAUNSTEIN: I understand the logic.

MEDICAID DIRECTOR FRESCATORE: -- they could implement the 2 percent.

So the proposal really is two measures, to answer your question. That if the localities grow their property taxes by more than 2 percent, they would be responsible for the Medicaid growth. For those localities that are within the property tax cap, they would be responsible for growth over 3 percent.

And then we had talked before about if the growth in those counties is less than 3 percent, they would share in the savings.

ASSEMBLYMAN BRAUNSTEIN: Okay. So as I said earlier, the City of New York has never been subject to the 2 percent property tax levy.
has always exceeded 2 percent. It's -- I think everybody understands that moving forward, for the way the city budgets, that it's probably not going to abide by the 2 percent cap.

2018-2019, Medicaid spending in the City of New York increased by 7 percent. So if we have another year of 7 percent, the city is supposed to pick up the entire 7 percent?

MEDICAID DIRECTOR FRESCATORE: It would be what the growth --

COMMISSIONER ZUCKER: The growth. It would be growth.

MEDICAID DIRECTOR FRESCATORE: -- was year over year.

ASSEMBLYMAN BRAUNSTEIN: Do you have an estimate of how much that's going to cost?

MEDICAID DIRECTOR FRESCATORE: I don't have -- I don't have -- I don't have --

ASSEMBLYMAN BRAUNSTEIN: Okay. Well, the city --

MEDICAID DIRECTOR FRESCATORE: -- on that. We know there are some --
ASSEMBLYMAN BRAUNSTEIN: The city has an estimate. The city Office of Management and Budget estimates that if it were to incur a 7 percent increase this year, that's a cost shift of $1.1 billion.

MEDICAID DIRECTOR FRESCATORE: We've seen that. We saw that -- we've seen that estimate. We did not compute that estimate. I don't have, you know, a separate estimate for you today.

ASSEMBLYMAN BRAUNSTEIN: Okay. Now, should the city somehow magically comply with the 2 percent tax cap, they would only incur 646 million. But, you know, I can't help but think that the inclusion of New York City with the 2 percent tax cap is nothing more than a mechanism to shift the entire burden of the Medicaid increase -- unfairly, compared to other counties that comply with the 2 percent cap -- to the City of New York.

And I'm very troubled by what they're estimating is a $1.1 billion cost shift. And considering the fact that the city has never been subject to the 2 percent tax cap, I'm
urging you to reconsider that requirement in
this proposal. Thank you.

CHAIRWOMAN WEINSTEIN: We've been
joined by Assemblywoman Griffin.

Then we're going to the Senate.

CHAIRWOMAN KRUEGER: Thank you.

Senator Jen Metzger.

SENATOR METZGER: Thank you, Madam
Chair. And thank you, Commissioner.

I represent the 42nd District, which
includes all of Sullivan County, the western
part of Orange County, Ulster, and Delaware
Counties. Very rural areas.

I want to start off first by just
echoing some of the concerns that Senator
Seward brought up, and comments on the
importance of emergency management services
having a seat at the MRT II table. And I
would ask that you make sure that there is
some geographic balance in that
representation, because rural EMS is really
struggling.

Secondly, I wanted to speak to the
proposed rural healthcare program
consolidation. I'm extremely concerned about that.

Our rural communities across the state are grappling with accessibility issues. In Sullivan County, the county ranks second from the bottom in health outcomes. So these are serious issues. This is actually a county that both my neighbor right here, Assemblywoman Gunther and I, both represent. Both Sullivan and Ulster Counties are in the highest quartile for opioid deaths in the state.

So I want to know, where is this $3.72 million in savings coming from? How is it going to impact the delivery -- the success of these programs to date, which are so important?

COMMISSIONER ZUCKER: So I'm unclear a little bit about your question. I mean, I recognize the challenge in Sullivan County very well. As a matter of fact, my family has a home in Sullivan County, so I've spent -- I've been there, spent time there.

Are you referring specifically to
SENATOR METZGER: I'm referring to the consolidation of the Rural Healthcare Access Development Program and the Rural Healthcare Network.

COMMISSIONER ZUCKER: Right, so I understand what you're saying. So we -- I will have to get back on the details of how we will find that.

But I will tell you, as I mentioned before, that the rural health issues are forefront on our agenda of trying to tackle, whether it's the issues of Sullivan County or any of the other counties in New York State that the -- a lot of burdens have been placed upon them, or the people who live there, as less -- the access to some care is not as robust as elsewhere.

So I recognize that. And we will figure -- I can get back to you about the details of where the money is going to come from.

SENATOR METZGER: Okay, I would love to get those details. Perhaps we can get
them in a break.

COMMISSIONER ZUCKER: We will do that, I promise you.

SENATOR METZGER: Okay. And my colleague would also like them.


SENATOR METZGER: And then lastly I just want to turn to the proposed regulation of pharmacy benefit managers. This is a program that started with great intentions but, you know, it's ended up costing consumers and really squeezing the independent -- we love our small independent pharmacies in our rural communities, and it's been a huge problem for them.

I want to know why, if you could just explain why the proposals do not include a prohibition on spread pricing, which has been --

COMMISSIONER ZUCKER: I didn't catch the second part.

SENATOR METZGER: A prohibition on spread pricing.
MEDICAID DIRECTOR FRESCATORE: I would -- Senator, if you'd defer that, actually, to our colleagues at the Department of Financial Services.

I think you all know that for the Medicaid program there was a prohibition on spread pricing in this year's budget. We require health plans and PBMs to --

CHAIRWOMAN WEINSTEIN: Would you -- it's hard to hear.

MEDICAID DIRECTOR FRESCATORE: I apologize. We required health plans -- is this better?

We required health plans and PBMs to present to us contracts that eliminated spread pricing, which they did, that went into effect on October 1st for Medicaid. It's too soon to know the dollar impact, but it was -- every plan had to renegotiate its contract.

But I would defer on the current Article 7 to the Department of Financial Services.

SENATOR METZGER: Okay, thank you.
CHAIRWOMAN WEINSTEIN: We go now to Assemblyman Jacobson.

ASSEMBLYMAN JACOBSON: Thank you, Madam Chair.

Dr. Zucker, I seem to be -- because of the importance of your agency, I seem to be writing letters to you every six weeks. I want to start out with a compliment. I thought that the ads you did on television concerning the vaccination crisis were quite excellent.

The reason I write to you all the time is I'm from the City of Newburgh, and we have the PFOS problem. And I was happy, though it took a while, you've instituted the new levels on PFAS/PFOS from the State Water Quality Task Force, which was long overdue.

And there was recently money awarded from the federal government to participate in a multistate testing concerning these chemicals.

And the reason, by the way, for those that don't know, the reason that the City of Newburgh's water supply has been
contaminated, that we cannot use it, is
because it was contaminated by the
firefighting foam used at Stewart Airport.
And because of that, we don't use it, we're
hooked up to the Catskill Aqueduct. And of
course my position has been that we should
continue to be hooked up to that, because I
don't think there will ever be appropriate
remediation.

But concerning the testing, I wrote to
you last month and I just received a letter
back from Dr. Ginsberg. I had requested that
when the testing was done, there would be
new -- that they retest people that had been
tested before so that we see if there's been
improvements and whether it has dissipated as
supposedly it's supposed to.

Dr. Ginsberg wrote back and said that
you were going to start new testing, which
would include people that had previously been
tested and those that haven't been. So
that's good to hear, and I'm very happy on
that.

The problem we've had previously in
the testing is there's not really been a
broad participation as much as there should
be. People are nervous, they don't like
getting their blood taken, all these things.
And I was hoping that you could work
something out -- and I understand privacy
rules, and I understand you have to get
consent -- but to work something out with
emergency rooms that too many people use as
their family doctor in Newburgh, and also at
the schools.

COMMISSIONER ZUCKER: I agree, I think
that this is a collaborative effort between
county and state on this. And I recognize
we've spent a lot of time on drinking water
and whether it's PFOA and PFOS or
1,4-dioxane. And I have learned that there
is sometimes some people don't want to be
tested --

ASSEMBLYMAN JACOBSON: But you could
do that.

COMMISSIONER ZUCKER: -- but we can
work with you and work with the community to
figure out what's the best way to get the
message out to everyone in the community
about testing and about what's the -- what
information it provides and what they could
learn from their result and when to be
retested in the future.

ASSEMBLYMAN JACOBSON: Well, one way
that you would get more people to participate
and less cynicism is that we need answers.

I mean, I had my blood tested. So you
got three different tests back. One said it
was median, one said it was above the median,
one said a little below. So I asked, "What
does this mean?" And every time I went to
the six or seven public hearings, the answer
was "We don't know."

COMMISSIONER ZUCKER: So that's part
of the challenges a little bit on the biology
aspect of this. We do know some information,
but we're learning more and more every day.
And ATSDR, which is the CDC branch, the
branch of the CDC that looks at some of these
issues on environment, they too have been
involved in looking at this on a national
level as to what does the result of X amount
mean.

We do know what the Governor asked us to do is to push forward on addressing drinking water quality, and we have the most -- the most restrictive levels in the nation. We've pushed the PFOA and PFOS down to 10 parts per trillion. We've pushed 1,4-dioxane down to one part per billion. We're moving forward on these issues. And we do know from some of the other tests in other parts of the state that the levels have dropped when we've done follow-up testing.

So we will move forward. I think what the answer to your question is is more education, more information to the public, and being able to share any view that we do know. But the one thing -- sometimes we don't have all the answers. And we will find that out as we go.

ASSEMBLYMAN JACOBSON: Well, I appreciate it. The only thing I was told, there was a likelihood I would die between 60 and 90 years.

(Laughter.)
ASSEMBLYMAN JACOBSON: But they didn't say it was from the PFOS. So we need more information.

COMMISSIONER ZUCKER: We'll get that for you.

ASSEMBLYMAN JACOBSON: All right, thank you.

CHAIRWOMAN WEINSTEIN: Thank you. Senate?

CHAIRWOMAN KRUEGER: Thank you. Our next testifier is Senator May, who I don't see. So we'll come back to her. Our next testifier is Senator Diane Savino.

SENATOR SAVINO: Good morning, Commissioner.

So we had an opportunity to speak earlier this week about medical marijuana, so I won't bore the audience with the content of the discussion.

I would like, though, to echo the concerns of several of my colleagues about the makeup of the MRT. I think it's critically important that EMS be on it. As
you see, there's so many of them here behind us.

Also, the New York City HHC. The last MRT they really did not have a role. And since they are the largest provider of Medicaid services in New York City -- they had a representative from the City of New York, but not the HHC itself. So we would hope that that would be part of it.

But I want to -- and also we spoke about my concerns about vaping. I know for a fact if we take -- if we ban the sale of vaping products, people will go to the illegal market. They do it now. And, more importantly, they'll go back to smoking cigarettes. So I think we should approach this in a more deliberative way.

If we really want to get people to stop using these products, we would demand that they take the nicotine out of the products. Because without nicotine, nobody is going to smoke or vape. It has no purpose.

But that being said, I want to talk
about you all have said numerous times today
the largest driving cost in the expansion of
Medicaid has been long-term care over the
past several years, and that's -- we all know
that that's true. And what's kind of curious
to me is with respect to the Medicaid
look-back period, for nursing homes it's five
years, but for long-term care it's only
30 days. And so do we think maybe it makes
more sense to extend the look-back period for
long-term care?

And then finally, if we know long-term
care is so extraordinarily expensive and
we're spending a disproportionate amount of
our Medicaid dollars on it, what can we do,
working with DFS, to encourage more people to
purchase long-term care? Because I hear from
many of my constituents who have invested in
a long-term care policy so that they don't
have to spend down their assets or give away
everything they have. But DFS has approved
premium increases and it's gotten to the
point where they can't afford the premiums
anymore. So we're kind of working at
cross-purposes.

What can we do to incentivize the creation of long-term care products that are sustainable for people so that they can have some dignity and they don't have to give away everything that they have and then rely on Medicaid?

COMMISSIONER ZUCKER: I think that's a good question. We should sit down with DFS and have a conversation about that. And I agree that people don't purchase it because --

SENATOR SAVINO: It's expensive.

COMMISSIONER ZUCKER: It's expensive and then the -- and it is a tough issue to talk about, because -- not here, but when you talk to relatives or others about long-term care and the worry about, well, what if you become incapacitated or there's a challenge, what are you going to do? And sometimes people shy away from that discussion and then they discuss it when it's almost too late.

And so I agree, we should have that conversation.
MEDICAID DIRECTOR FRESCATORE: Hi,

Senator. I would just add that I think that
the reconvening of the MRT gives us an
opportunity to talk in a more focused way
about long-term care than the first round,
and also exploring ideas like the one you
just, you know, discussed about different
options that make it possible for people to
contribute, you know, on a private-pay basis.
And we would concur that we would want to
work with DFS on the premiums and other
strategies for people to keep their, you
know, private money in the system as well.

SENATOR SAVINO: Several years ago we
adopted legislation that would allow people
to accelerate their death benefit on their
life insurance policies. Life insurance is
relatively inexpensive to purchase. And you
could, instead of leaving it to your
relatives, you could accelerate the death
benefit to pay for nursing home care. Maybe
we can explore expanding that to long-term
care as well.

Thank you.
CHAIRWOMAN KRUEGER: Thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

Assemblywoman Gunther.

ASSEMBLYWOMAN GUNTHER: Good afternoon.

My question has to do with the study regarding safe staffing. We've been talking about this issue year after year. We've put off the issue for a long time, stating that safe staffing, we had to do a study. And I know as a physician you know that education is important, and who gives education to inpatients is the nurses.

Also we know that nurses are leaving the profession earlier and earlier because, number one, their license, and number two, we get in that business not to be rich but to provide good care.

We have put this off for a very, very long time. I've had many administrators from hospitals come and talk to me about it, about the cost. But right now, with the nosocomial infections and the rate of nosocomial infections in our hospitals, that is causing
increased length of stay, also readmittance to the hospital, and also bad care.

And as a nurse and as someone that has been picketing for the last 13 years with no answer, only pushback, pushback, you know, we're waiting for something to happen. So tell me the end of the study, tell me what it told me, and tell me why that right now we're not following Australia, another country, or California to see that it didn't devastate hospitals; rather, it provided better care.

COMMISSIONER ZUCKER: So I -- on the report, we're finalizing that report. And as you know and probably most people know, I don't like to issue reports or put things out until I have looked at everything to make sure all the Is are dotted, all the Ts are crossed. And so we're working on that. And that will get done, and I assure you we will get that to you.

I will echo your words of the role of nurses, as I have worked with many nurses and I know that we -- I couldn't do my job when I was practicing without their assistance and
their professionalism and what they do in
taking care of patients at the bedside. So I
hear you. I hear you.

ASSEMBLYWOMAN GUNTHER: Dr. Zucker,
you know, I've heard that it will get done,
and it's been put off and put off. Like for
me, I pay my electric bill on the 15th of the
month. So there should be a date certain.
At least it would be an answer that we would
have a level of comfort. You know, the
nurses in Cornwall Hospital, in St. Luke's
Hospital, you know, we've been waiting a
very, very long time. And we are the
backbone of healthcare. We stay with our
patients. And if you look at the ratios on
the hospital I hear about, and the meds are
more complicated, people are living longer --
so this is like time to do it. They've done
it other places. We've put this off.

You know what? I'm probably going to
get killed for this one, but if you look at
what the salaries are of the administration
of hospitals -- and we talk about Medicaid
and the low reimbursement, that the
difference between the reimbursement -- you
know, if you go to a European country, it
don't look like that. It just doesn't. And
at this point we've waited long enough. We
are the backbone of hospitals and medicine.
We also mostly are women. And I repeat,
mostly women. We're angry women now, and
that's not a good thing.

(Laughter.)

COMMISSIONER ZUCKER: That's not a
good situation.

ASSEMBLYWOMAN GUNThER: That's not a
good thing. I'm from the Bronx. You know,
we're kind of tough from the Bronx. But we
are women, and we want an answer and we want
it as soon as possible. A study -- you know
what, Doctor? You know that when you look at
something and you look at any trends, that it
doesn't a year long to actually say what is
happening here. It really doesn't. You know
that.

We used to do studies for years and
years, and they said to us: You know what?
That's ridiculous. When you see a trend,
it's telling you a story. The story is being
told, and it's been told by women over and
over again. And so I am requesting, asking
politely to please give us the answer that we
want. We need more staffing.

COMMISSIONER ZUCKER: I hear you.
CHAIRWOMAN WEINSTEIN: Senate.
CHAIRWOMAN KRUEGER: Just for the
audience, if you like something you hear, we
discourage clapping. This (gesturing) is
fine.

(Laughter.)

CHAIRWOMAN KRUEGER: Okay? This
(gesturing), not this. There you go. Thank
you.

Next up is Sue Serino.
SENATOR SERINO: Thank you, Madam
Chairwoman.

And I just want to echo my colleagues'
comments about our EMS and our nurses. As
somebody who just shattered her ankle this
winter, they were both so important to me.
So thank you for all of you being here today
as well. Greatly appreciated, thank you.
Dr. Zucker, so great to see you. I can't count the amount of times that we've talked about this subject, but Lyme disease. So you know I'm always talking ticks. (Laughter.)

SENATOR SERINO: But in last year's, you know while the Senate did include a million dollars in their one-house proposal, ultimately it was left out of the final budget. Towards the end of the session we did put some funding in, but it was a real significant cut that we just can't afford from prior years.

Now, I know in the past you and I have talked about bolstering public/private partnerships when it comes to Wadsworth and such. But the money that we add goes directly to research and prevention initiatives that we know are actually working here in the state. You know, of all the different places that we provide -- have provided the funds for, it's very important.

So I have two questions, and I'll ask them one at a time. What do we have to do to
ensure that the administration makes funding
to combat Lyme and tick-borne diseases a top
priority?

COMMISSIONER ZUCKER: So first, we are
working diligently on this issue. Between
DOH, DEC, we put out thousands of signs, I
think 8,000 signs, just notices about ticks,
particularly, obviously, during the season.

We are -- we have -- once again, when
tick season begins again, we will test
150,000 ticks again. We are working on the
issues of education to the public about this.
We are working and trying to get
public/private partnerships on this issue.
We recognize that the Lone Star tick and the
long-horned tick and all these different
specific ticks, whether it's out on Long
Island or elsewhere in the state, are of
concern.

We looked at all the issues of tick --
not just Lyme disease, but babesiosis,
ehrlichiosis, anaplasmosis, Powassan, all the
different other tick-borne diseases. And we
are working aggressively on this.
I was thinking about this issue the other day because I was saying that, you know, when I was a little kid I used to roam around with my grandmother, picking blueberries, and I didn't remember some of these issues of getting -- that I wasn't bitten by a tick. And so all these issues. And there were deer there and everything in the area. And I realized that this is something which is growing, and it's growing as the change in climate is growing, as the many different changes that have taken place in our environment.

And so we are aggressive on this. Wadsworth, as you mentioned, our lab, is working hard to address the public/private partnership as well.

SENATOR SERINO: And I live in the Hudson Valley, so of course we are the epicenter. So -- and I appreciate all of the work that you're doing with the public/private partnerships. But I want to ask you this question, because this is really directly to what we need to do with these
specific locations.

Would you be supportive of putting at least the million dollars to support the Lyme and tick-borne disease research and prevention initiatives in the 30-day budget amendments?

COMMISSIONER ZUCKER: So let me get back to you about that, because of this -- you know, about -- I've got to look at all that. But I hear you. I hear what your concerns are. I've got them here.

SENATOR SERINO: And then in the past I've sponsored legislation that would require the Healthcare Quality and Cost Containment Commission -- so especially for my new colleagues, Healthcare Quality and Cost Containment Commission -- to consider mandating insurance coverage for chronic Lyme. As you know, the commission was supposed to look at how much insurance mandates would actually cost and the impact that they would have on quality of care. So that's actually something that makes a lot of sense, right? Look at the cost, look at the
care. Whoever thought of that idea for the

cost containment commission, it was

brilliant. But the Assembly never appointed

its members to the commission, and as a

result, the Governor decommissioned it.

So given our current fiscal situation,

would the administration be supportive of

reinstating the Healthcare Quality and Cost

Containment Commission to ensure that all

lawmakers had access to this important

information when we're making these

decisions?

COMMISSIONER ZUCKER: We'll look at

that.

SENATOR SERINO: You'll look, okay.

Thank you.

And the last thing I wanted to ask

about was can you clarify whether or not

there's a cut being proposed to EPIC, a

program that many New Yorkers, seniors,

depend on to help pay for costly prescription

drugs?

COMMISSIONER ZUCKER: So we're looking

at the issue of -- just the overall issue of
the cost of prescription drugs, whether it's
for the elderly or for anyone, for that
matter. And trying to -- as the Governor has
said, that we need to figure out how to lower
the prices that are just -- some of them are
just exorbitant, whether it's medicines, for
insulin, as he raised, but also just in
general, and what else we can do. And
there's a whole team in the department trying
to address this as to how to lower costs.

MEDICAID DIRECTOR FRESCATORE: If I
could say specific to EPIC, Senator -- thank
you, Dr. Zucker -- there is a reestimate of
the cost of the program related to the
closing of the Medicare donut hole.

SENATOR SERINO: Okay. Because I
wanted to know, too, about the line in the
Executive Budget about the amendment.

Also, the financial plan says that the
EPIC program will be adjusted to reflect
decreasing program utilization, but I'm being
told that it is not being cut.

So it's kind of like we're going back
and forth on it. It's a little confusing.
And I know we still do a lot to try to
educate our seniors about --

MEDICAID DIRECTOR FRESCATORE: Yes.
SENATOR SERINO: -- that EPIC program.
MEDICAID DIRECTOR FRESCATORE: Yes.
SENATOR SERINO: So I'd hate to see it
cut.

MEDICAID DIRECTOR FRESCATORE: It's
certainly a very important program to
hundreds of thousands of elderly New Yorkers.
And I think that reference -- and
we'll get you a clarification on exactly what
it is -- is a reference to the donut hole
under Medicare Part D closing. And because
the EPIC program works as secondary payer to
Medicare Part D, that there's efficiencies in
the program that just result from Medicare
not having that hole anymore in coverage. It
was a multiyear phase to close that donut
hole. But we'll get you some clarification
on that.

SENATOR SERINO: Maybe we can talk
about it afterwards. It's such a great
program, and important.
Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Assembly.

CHAIRWOMAN WEINSTEIN: We go to Assemblywoman Miller.

ASSEMBLYWOMAN MILLER: Good morning.

So I have a few questions, I'll ask them all at once. First, in light of this overall deficit problem, it may seem crazy for me to be asking about this, but as you are very familiar, it's an issue that I've been very concerned about. And if anything, this budget challenge has only enhanced my concerns.

How are we ever going to address the emerging crisis of not having skilled care providers in home care environments if we don't find a way to pay the skilled care providers a competitive wage? There are more and more individuals with complex health needs that are living longer and living in their home care environments. But the lack of a competitive increase in the RN/LPN rates over the last many years has caused a
shortage of nurses to provide this care.

A nurse in the hospital, as you know, makes about double what a nurse in home care makes. And in the hospital, they have benefits. Often in the home care environment they're not offered benefits.

This crisis in itself is forcing families to provide that skilled care, at a cost. We've had to stop working or limit our hours or work double time. In my case, I work all day, often seven days, and then at night I'm my son's nurse, I'm doing skilled care. You have burnout.

And then on the other end of it, where this has inadvertently increased the CDPAP usage, because families are relying on other family members. They'd much rather have somebody that they know who cares about their loved one provide that skilled care that they can't get. And now that program is being targeted because of that increase in its usage. So how on earth are we going to address this dire need?

My other question is the 1 percent
across-the-board tax cut for hospitals that have other revenues, it hasn't really been so devastating. But for these other community groups and post-acute care groups, it has been devastating. They're already struggling. And if there are more increases, how are they going to continue to provide these services and the care that we need to keep them in the community?

Does anybody -- I know you don't know the makeup of the MRT, we've heard this over and over. But can we beg you to make sure that there are representatives that will be looking out for this increased need in the home care environment. You know, Assemblywoman Gunther made that story -- you know, you see a trend, it's telling a story. Well, this story is just growing. And it's indicative of a lot of people's lives across this state.

COMMISSIONER ZUCKER: I hear you. I hear you on the issue of the home care. We have had multiple meetings about this, and they continue. And I've brought in home care
agencies to discuss this exact issue about
how do you create an increase in professional
development so that if someone doesn't feel
it's just a job, that they can grow and
develop in the course of their career. How
do you give them more autonomy so that
there's a feeling that I am not restricted to
doing a certain number of things.

This is -- scope of practice issues,
this is something which we are -- it is
actually on the forefront of our issues in
the department. And I believe I actually
have a meeting with the home care agencies
again somewhere in the coming month to
discuss this.

And I hear you about this. And I do
hear you saying that it falls upon family
members to do this. And as one who had an
elderly dad, I recognize the amount of need
that home care provides. On the --

ASSEMBLYWOMAN MILLER: The home care
agencies will say that they can't do it
without money to pay a better wage.

COMMISSIONER ZUCKER: Right, I
understand. On the CDPAP, maybe Donna could
address that aspect of it as well.

MEDICAID DIRECTOR FRESCATORE: Yeah, well, I would -- first of all, thank you for
the conversation that we've had over the past
many months on your concerns, particularly
about, I think, the availability of skilled
nursing in the home. And I think you've made
us, you know, certainly acutely aware of the
need and some of the reimbursement issues.

And, you know, we work case by case,
patient by patient to ensure that we're able
to put -- there's services in place. But we
would agree that we need a longer-term
strategy to address that. And so we're
hopeful that -- we hear about the MRT and the
representation, and that as that reconvenes,
that the importance of that part of care in
the home will be considered as well as the
other programs that are providing millions of
hours of care. So we appreciate that.

On the 1 percent across the board, if
there -- there are some providers who are
exempt from that and some -- so if you have
specific providers, maybe offline -- or types of providers -- we can talk about how it would impact them through implementation if you would like.

ASSEMBLYWOMAN MILLER: Okay. And I just think, in closing, that, you know, we keep this trend of, you know, what's the biggest drain? Long-term care. But it's the thing that continuously gets cut. It's like the first thing on the chopping block is -- but the trend is long-term care. Why do we keep pushing it aside or pushing it to the bottom?

CHAIRWOMAN KRUEGER: Thank you. I'm going to cut you off now. Thank you.

Senator Alessandra Biaggi.

SENATOR BIAGGI: Thank you,

Madam Chair.

Donna, Commissioner, thank you very much for being here.

Commissioner -- and I'm going to be very cognizant of my time. In 2016 and 2018, unprecedented language was added to the State Budget at the very last minute authorizing
DOH to extend two specific contracts with Maximus Inc. without being subject to the state standard procurement laws. Since then, your department has quietly and without competition or OSC review and approval, extended and expanded these two contracts so that they are now collectively valued at $3.6 billion, which is almost 12 times larger than their original value.

One of these contracts is for the New York State of Health Customer Service Center, which was originally valued at $170 million, but following three expansions and extensions is now valued at 2.46 billion, which is about 15 times larger than its original award.

The second contract, for Medicaid enrollment broker services, was originally awarded for $140 million, and DOH has also extended this project without competition or OSC review. The most recent three-year extension for this contract almost doubled the value of this contract to $1.14 billion, suggesting that New York's spending on these
services for the next three years will be
roughly equal to what it spent over the
previous nine years.

Especially given the severe crisis
that we currently face -- and we've been
talking about all morning -- in Medicaid
funding, which puts many vulnerable enrollees
at risk of limited or reduced services, the
lack of competition or even oversight for
these massive contracts raises very serious
concerns.

We know that there's been a history of
New York overpaying Maximus on at least one
of these contracts. Audits by the OSC of
MAXIMUS's New York State of Health customer
service contract in 2014 and '15 found that
New York was paying the company excessive
profit fees. It also found billing abuses
such as Maximus charging the state to put
employees up at $595 a night deluxe hotels,
and charging fringe benefit rates of
86 percent for some employees.

Nationally, we also know that Maximus
reports an 18.8 percent profit on its state
contracts. New York State is MAXIMUS's largest state client -- largest state client -- accounting for fully one-third of its state business. This profit rate is almost double MAXIMUS's profit rate on its federal contracts, and seven times larger that on its non-U.S. business.

Given the absence of competition and OSC oversight and the circumvention of all regular contract oversight procedures, what measures is DOH taking to ensure that Maximus is not abusing its contracts with New York State and is earning a reasonable rather than an excessive profit?

MEDICAID DIRECTOR FRESCATORE: So I'll be happy to respond to that, Senator. I think as you know, in a couple of places there was state legislative authority to be able to extend a contract for existing services.

CHAIRWOMAN KRUEGER: Just put the mic a little closer.

MEDICAID DIRECTOR FRESCATORE: Sure.

SENATOR BIAGGI: And can you start
over? Because it's very hard to hear you.

MEDICAID DIRECTOR FRESCATORE: Yup.

Is that better?

SENATOR BIAGGI: Yes.

MEDICAID DIRECTOR FRESCATORE: So as you noted, Senator, there's been provisions in state law that have allowed the department to extend the agreement for certain services and contracts -- in this case, contracts that were provided by Maximus -- in order to continue services to consumers and to meet time frames.

The one contract that you noted in particular was related to the standing up of the New York State of Health marketplace, particularly given the very short time frame, and that Maximus was doing customer services already.

SENATOR BIAGGI: I got that. But how -- just let me -- let me just -- I want to get to the point, because our time is running and I have one more question and I really want to make sure I ask it.

How are you ensuring that we're not
abusing -- that they are not abusing their contracts with New York State and that their profit is actually reasonable and not excessive? Because considering how much we're paying them, in a year where we have a $6.1 billion deficit, that seems excessive.

And I think any New Yorker, whether they're a millionaire, a billionaire or middle class, low income -- it doesn't make a difference -- I think every person would agree that's a very high number for a contract.

MEDICAID DIRECTOR FRESCATORE: So let me address that quickly so you can get your other question in.

SENATOR BIAGGI: Yup.

MEDICAID DIRECTOR FRESCATORE: We certainly have been very mindful of the recommendations of the Office of State Comptroller. As a result, we have made changes in how the contract operates and how it is built, including a reduction in the profit that's allowable under those contracts. Since 2016, the Office of State
Comptroller has had no findings on their review of those contracts.

SENATOR BIAGGI: Okay, let me just stop you there. Thank you for answering that question.

Is there a reason specifically for singling out MAXIMUS's contracts without competition or oversight? Why just them?

MEDICAID DIRECTOR FRESCATORE: I think as I stated earlier, the contract -- it was an extension of work that was already being done, and the time frames to implement were very short in order to stand up the marketplace.

So we are -- I'm happy to talk about this more offline, and we are aware of the report about --

SENATOR BIAGGI: I don't want to talk about it offline, because I would like for it to be -- I'm a very transparent person, so I want to make sure that everybody knows.

MEDICAID DIRECTOR FRESCATORE: Okay.

But if I could just finish, because I think, you know, you also referred to some of the
concerns that were raised in a recent report about MAXIMUS's operations in other states.

So we've reviewed that report as well, and we are committed to ensuring that, you know, that any contract that we hold is -- you know, the terms of it are fair and responsible and in the interests of not only consumers but the taxpayers. So we are reviewing that report.

The services Maximus provides for New York are different than in those other states, but nevertheless it's important information, and we are reviewing it.

SENATOR BIAGGI: Thank you.

CHAIRWOMAN KRUEGER: I think this is one of those areas where -- I'm sorry. As I announced earlier, I think this is one of the areas where we would like some of those questions that were thrown at you responded to in writing to the chairs.

MEDICAID DIRECTOR FRESCATORE: And I believe that those responses are in process, if they've not already been sent out.

CHAIRWOMAN KRUEGER: Thank you.
Okay, Assembly.

CHAIRWOMAN WEINSTEIN: We've been joined by Assemblyman Abinanti, and we go to Assemblyman Charles Barron now for some questions.

ASSEMBLYMAN BARRON: Thank you.

Commissioner, I'm sure you will agree with me that we live in a racist, parasitic, predatory capitalist system that uses healthcare as a profit. As a matter of fact, most of the profit -- high profits during whether it's Obamacare or Trumpcare, the private health insurance companies are laughing their way to the bank.

And the prior speaker just raised a question around contracts. I resent that every year when this state has a deficit, we look at Medicaid. Medicaid, $23 billion. In a $178 billion State Budget, we pick on Medicaid. And then you use the term "savings." Why don't you say it -- what it is? It's cuts. It's cuts. But you all use cute language like "savings." The Medicaid Redesign Team is going to come up with
savings. Those are cuts. Those are cuts in a budget that's giving out multi-billion-dollar contracts. Those are cuts in a budget where the developers get subsidies, billions of dollars of subsidies, to make money and they call -- when they get free money, it's subsidies. When we get free money, it's welfare. Well, we're all on subsidies or we're all on welfare.

So my question to you is about Medicaid. We need to stopping targeting Medicaid to balance the budget when 80 percent of the hospitals in black and brown struggling communities count on Medicaid. In the more affluent white communities, they have private health insurance.

So when you focus on Medicaid and continue to cut Medicaid like we're doing every year, we have a major problem. I'll be glad when we finally pass the New York State Health Act, the New York Health Act, where we have Medicare/Medicaid for all and where healthcare is free. Struggling countries do
it. Countries in Africa, countries in the
Caribbean, countries in Latin America,
countries in Europe have free healthcare.
And here in the richest country on the
planet, we can't carve out any free
healthcare for our people.

So I'll be glad when we do pass the
New York Health Act, which will provide
healthcare for all, and it will bring down
premiums, bring down copayments, and make it
more viable.

Everybody in this state, human beings
deserve, they have a right to affordable,
quality healthcare. And all of this nonsense
around budget time focusing on cutting
Medicaid is a disservice to this state.

So I want you to reconsider language,
and the mission for the redesign team should
not be savings. We need more. And the
reason why it's not just long-term care
that's causing the rise of Medicaid to go up,
people are becoming poorer and poorer, so
they need it. You want to bring down
Medicaid, bring down poverty and give us the
right to have healthcare.

COMMISSIONER ZUCKER: So I appreciate your thoughts. And I will say that we have 18 million people out of 19-plus million people in this state who are covered under insurance, whether it's Medicaid or New York State of Health. And I think that as I mentioned before --

ASSEMBLYMAN BARRON: But since my time is tight, when you say "are covered," premiums, copayments are still very, very high. So people may be covered, but some -- and it doesn't cover everything. The New York Healthcare Act is universal, it's single payer, and it covers everything. And it will bring the costs down for everything in this state.

So when you say people are covered, that's the same thing they say nationally, people are covered. Try going to your dentist and use your healthcare and see what the dentist says, if you think they're so covered. So that's not even adequate.

COMMISSIONER ZUCKER: I do feel that
with regards to when you're saying that we're focused on Medicaid. But we are looking at the entire budget. Medicaid is a large part of this State Budget, of the Department of Health budget, and so the --

ASSEMBLYMAN BARRON: Well, that's because we have a lot of poor people, that this state allows poverty to happen. You know, there's 30 and 40 percent poverty in black and brown communities in New York City and across this state. So once you allow that kind of poverty, you're going to have a need for Medicaid.

COMMISSIONER ZUCKER: And one of the things that we are looking at is all these other social determinants of health. So you bring up the issues of poverty, housing, nutrition, all these other areas. And these are some of the areas that the Governor has addressed on some of the Health Across All Policies --

ASSEMBLYMAN BARRON: Like Martin Luther King said, maybe it's time for America to move to more of a socialist economy than a
capitalist one.

CHAIRWOMAN WEINSTEIN: And with that note, we go to the Senate.

CHAIRWOMAN KRUEGER: I don't think I saw that in the Governor's Budget, Charles, but thank you for that proposal.

Excuse me. Our next is Robert Jackson.

SENATOR JACKSON: So good afternoon.

COMMISSIONER ZUCKER: How are you.

SENATOR JACKSON: It's a great day in New York, right?

COMMISSIONER ZUCKER: Always is. The sun is shining.

SENATOR JACKSON: Well, let me thank you for coming in front of us.

So people talk about the -- in 2011 the Governor created the MRT team, and there's a cap. So how come the cap is not realistic? Why don't we get rid of that cap and do what's realistic as far as providing all of the people on Medicaid the type of health coverage that they need?

COMMISSIONER ZUCKER: Well, I think
one part of it -- and Donna could chime in --

one part is that MRT did do what it was
supposed to do, it did move forward on
addressing many of the challenges that we did
have. That was 2011, 2012.

And now we're in 2020, things have
changed. The issues that we're facing are
different. And we've heard about it from
your esteemed colleagues that there are other
issues that we're facing, whether it's home
care, long-term care, and that we need to,
when we do MRT II, address some of those as
well.

But Donna, did you want to add
anything?

SENATOR JACKSON: But Commissioner, is
there still that cap from before? That's the
question. And if the answer is yes, why are
we dealing with a cap that was put in place a
long time ago and not realistically what we
need today?

COMMISSIONER ZUCKER: Well, we look
at -- MRT II, we'll look at --

SENATOR JACKSON: So first of all, is
there still the cap?

COMMISSIONER ZUCKER: Well, there is
the cap. And we will look at --

SENATOR JACKSON: So that cap has been
there for how long?

COMMISSIONER ZUCKER: Well, from 2011.

SENATOR JACKSON: Come on, that's
unrealistic. Don't you agree?

COMMISSIONER ZUCKER: Well, we need to
look at --

SENATOR JACKSON: No, I'm asking you a
question. Do you agree that's unrealistic
from 10 years ago?

COMMISSIONER ZUCKER: No, I think that
the purpose of what the cap achieved was
control of the spending that
was skyrocketing --

SENATOR JACKSON: But that was then,
Commissioner. We're talking about now.

COMMISSIONER ZUCKER: Right. Well,
now, this is why the Governor has put forth
the goal to have an MRT II to look at all the
issues that we have. The MRT I, if we want
to call it that, achieved the goals that were
set forth at that time. And so now we will
look at this. And it is an evolving process.
And many of the things that were raised here
are the things that we will need to address.

SENATOR JACKSON: And I'm glad. But
that -- my understanding is that if the MRT
team comes with the fact that if we don't
accept, then there's going to be a
$2.5 billion cut and there will be layoffs,
is that correct, if in fact we don't agree
with it? Based on your knowledge?

COMMISSIONER ZUCKER: I'm not saying
that. I'm saying that we need to look at all
the -- everything is sort of on the table as
we move forward from here.

SENATOR JACKSON: Let me express to
you the concerns. I had a meeting at
Isabella Geriatric Center in my district with
a thousand 1199 employees that are very
cconcerned about the survival of institutions
like Isabella and other nursing homes that
provide services for the needy, okay, and
they're concerned about the lack of funding,
and possibly layoffs.
Are you concerned about that, there may be layoffs if in fact MRT team No. 2 comes with a situation that's unacceptable to the State Legislature?

COMMISSIONER ZUCKER: I think we're -- you're making some predictions which are not necessarily to be the case at all. No one wants to cause anything that will jeopardize the care of those in New York, whether it's in nursing homes or hospitals. And so we -- we need to look at how to do this, how to move things forward, how to be even more efficient than perhaps we have been, and how to make sure that the services continue to be provided.

But it may be that -- you know, sometimes everyone says, well, it's all about just money. But the reality is that when we look at providing services, sometimes it's figuring out how to be more efficient and doing things differently. And we've done that over the course --

SENATOR JACKSON: Without decreasing services, though, is that correct?
COMMISSIONER ZUCKER: Right, without -- of course without decreasing services, right. Just to be more efficient and figure out maybe there's a way to do this. And I think that we have to look at it that way.

SENATOR JACKSON: Now, there's a caveat for New York City, right, if New York City -- what is that cap? If not, then there's cost factors going to have to be observed by localities.

MEDICAID DIRECTOR FRESCATORE: So there's not a separate New York City cap, Medicaid global spending cap, it's an overall cap.

And just to answer your question, Senator, yeah, the cap remains in place, it's a rolling increase. So every year it goes up. The issue is whether or not it's gone up enough to cover the cost of increases in care, our aging population. Remember, it's been tremendously successful. We reduced the number of uninsured immensely -- I mean, a million more -- more than a million.
additional people got Medicaid under this cap.

But the question is, and I think what you're raising, is it's time to look at the cap again, right? A number of years has gone by. And I think that -- I look at the cap as a tool, a metric, to look at how spending is. But I think --

SENATOR JACKSON: Director --

director --

MEDICAID DIRECTOR FRESCATORE: -- the metric itself is up for discussion.

SENATOR JACKSON: Director, I apologize, I've got only 15 more seconds.

My question is this with respect to -- so every year that cap has been exceeded, is that correct? And that's why we had the $1.7 billion deficit from last year?

MEDICAID DIRECTOR FRESCATORE: It has not been exceeded every year. But that year it was exceeded. There were some years it was not exceeded.

SENATOR JACKSON: So why is it that we have a $6.2 billion deficit and 4 billion of
that is Medicaid, then?

MEDICAID DIRECTOR FRESCATORE: For reasons I think that we kind of outlined before, including enrollment increases, including more long-term-care services, including Medicaid's appropriate share of paying minimum wage for healthcare workers. It's for what we enumerated.

But we would agree that with -- you know, 10 years has gone by, almost, and that we should be looking at the cap again. And we think that, you know, that's one of the reasons to reconvene this group, to say is that the right metric to still be looking at.

SENATOR JACKSON: Thank you. Thank you, Madam Chair.

CHAIRWOMAN KRUEGER: Thank you.

Assembly.

CHAIRWOMAN WEINSTEIN: We go to Assemblyman Blake.

ASSEMBLYMAN BLAKE: Good afternoon.

On your New York State Health Equity Report of April 2019, on page 5 -- and this is for context and reference before going
into today -- you indicate: "The report indicated that blacks and other minorities accounted for 60,000 excess deaths each year and identified six causes of death that represented more than 80 percent of mortality among racial and ethnic minorities compared to whites." That's from your own report, Commissioner.

We would acknowledge that there are disparities when it comes to communities of color. Would that be accurate?

COMMISSIONER ZUCKER: I'd agree.

ASSEMBLYMAN BLAKE: Can you convey the intent of the DSRIP program, Commissioner?

COMMISSIONER ZUCKER: The intent --

ASSEMBLYMAN BLAKE: DSRIP.

COMMISSIONER ZUCKER: Yes, what about -- what is your specific question about DSRIP?

ASSEMBLYMAN BLAKE: Can you explain to everyone what is the intent of DSRIP?

COMMISSIONER ZUCKER: Well, the DSRIP program was to -- one of the key things here was to decrease hospital readmissions and
decrease use of emergency rooms. And -- and
if -- we also put out a report that gave
examples of the success of the DSRIP program
with specific examples of that.

ASSEMBLYMAN BLAKE: Understand. Just
one question. What was the dollar amount of
the first DSRIP program?

COMMISSIONER ZUCKER: I have to --
Donna, do you know that?

ASSEMBLYMAN BLAKE: Was it essentially
$8 billion?

MEDICAID DIRECTOR FRESCATORE: It
was -- it was roughly that, 8 billion federal
dollars given to reinvest. You're exactly
right.

ASSEMBLYMAN BLAKE: How much of that
$8 billion went to community-based health
centers to address the concerns of
communities of color?

COMMISSIONER ZUCKER: So I know this
question comes up about the fact that most
things went to hospitals --

ASSEMBLYMAN BLAKE: (Overtalk.)

COMMISSIONER ZUCKER: I don't have the
exact number, but I recognize that the feelings that the community health centers and just community health is something which many people feel is not being addressed as much.

But we have, in the course of the last five, six, seven, eight years --

ASSEMBLYMAN BLAKE: I understand.

COMMISSIONER ZUCKER: -- we have recognized that there is a move, obviously, towards more of community health. And we will work towards achieving the goals of what you're asking --

ASSEMBLYMAN BLAKE: So very specifically, there is a DSRIP II that is currently enacted --

COMMISSIONER ZUCKER: Yes.

ASSEMBLYMAN BLAKE: Correct. Have you submitted community-based health centers in that current proposal?

MEDICAID DIRECTOR FRESCATORE: We've not submitted any providers or types of organizations in that current proposal.

What we did do, though, was we laid
out a new structure where community-based organizations must be part of the governance of health -- population health entities. And we've also requested from the federal government funding for a new program, the Social Determinant of Health Networks --

**ASSEMBLYMAN BLAKE:** Understand.

**MEDICAID DIRECTOR FRESCATORE:** -- that would be led by community-based organizations. DSRIP has given us an ability that we didn't have before --

**ASSEMBLYMAN BLAKE:** Absolutely. So --

**MEDICAID DIRECTOR FRESCATORE:** -- which was to use Medicaid dollars to work on housing and hunger and literacy, right?

**ASSEMBLYMAN BLAKE:** Absolutely. So just for clarity, in the first $8 billion, community-based health centers were not included in that. And currently, as of now, there's a current consideration, but it's not clear how that will be defined. I'll put a pin in that.

Can you -- are you aware of the Diversity in Medicine program that we have
here in New York State?

COMMISSIONER ZUCKER: I do, yes.

ASSEMBLYMAN BLAKE: Is there a reason given -- that your own data that you all, in terms of the Governor's administration, propose zeroing out that program?

COMMISSIONER ZUCKER: Well, so I just want to say that there is a commitment to the issues of diversity in medicine across the board --

ASSEMBLYMAN BLAKE: Very specifically, can you just rationalize, given your own data, why did you propose zeroing out the Diversity in Medicine program?

COMMISSIONER ZUCKER: Well, we were looking to -- obviously, tough fiscal times, and we were looking at all the programs and figuring out is there somewhere else that there could be the needs met that those programs provide. And we are -- we are trying to move that forward.

ASSEMBLYMAN BLAKE: Commissioner, let's go a step back. And I know time is tight.
Your own report from April 2019 said
80 percent of higher excess deaths were
happening among communities of color. But
you all proposed eliminating completely
funding for the Diversity in Medicine
Program. Second, and a part of that,
community-based health centers, which, as you
would know as a medical professional,
overwhelmingly there would be higher
likelihood of helping communities of color.
I'm just trying to understand, why
would that be the approach, given the data?

COMMISSIONER ZUCKER: So I understand.
Like I said, these were challenges that we
were faced with. But when we looked at those
challenges, we sort of said, are there other
areas where some of the needs are met? For
example, the maternal mortality program,
which --

ASSEMBLYMAN BLAKE: Is there any other
funding area for diversity in medicine --

COMMISSIONER ZUCKER: Right, well, so
I'm going to bring up diversity in medicine
in general. One of the big issues that came
out of the maternal mortality listening
sessions was that the reason there's
disparities between the African-American
population and white population when it comes
to OB-GYN was there isn't enough diversity --

ASSEMBLYMAN BLAKE: Understand.

COMMISSIONER ZUCKER: -- in there, and
so we said, okay, let's see how can we move
that forward as the -- as a result of the
discussions we had.

So it's not like just because
something's not on that line, it's not being
addressed elsewhere.

ASSEMBLYMAN BLAKE: Commissioner, you
and I have been in part of many conversations
over the years. I think we can both
appreciate when you zero out a line item,
that's conveying a sense of priority.

So coming from the Bronx, which has
been the most unhealthy county in New York
State --

COMMISSIONER ZUCKER: I lived there.

ASSEMBLYMAN BLAKE: -- it is

perplexing to me that you would zero out the
Diversity in Medicine Program as well as not have a clear indication on what's happening in our community-based health centers. And it would be our expectation you all will resolve that when the budget is finalized.

Thank you.

CHAIRWOMAN WEINSTEIN: Senate?

CHAIRWOMAN KRUEGER: Thank you.

Senator Pat Ritchie.

SENATOR RITCHIE: Commissioner, I have two questions for you. The first one is a question that I believe we spoke about last year, and that's the shortage of rural doctors and nurses, especially in the North Country.

So I'm wondering what has been done in the last year or what is the plan to address it. Because we're at the point now where in some hospitals, beds are not being opened because of the shortage.

And the second one is on the critical status of our nursing homes. Over the nine years I've been in here, I've had a number of nursing homes who have closed. And when they
closed, the remaining ones were financially stable. We're now at the point where the ones that were financially the strongest, they're calling on a regular basis saying that they're in the red and many times they can't make payroll. And that's something that's so important to our communities.

So I'm just wondering, on those two, what is the plan?

COMMISSIONER ZUCKER: So on the first one, with rural health, as I mentioned before, this is a priority of the department. We have been working in the North Country particularly about how to address some of these challenges, and particularly in the areas where someone could drive 50, 60 miles until they get to a physician, let alone perhaps the physician is a subspecialty physician to the need that they particularly have. And so we are working on that.

I believe that the model of what we are doing in the North Country will be able to be replicated elsewhere -- not just here, but it will be a model for the rest of the
nation, I believe.

So that's one part. And we are aware of these challenges and we're trying to figure out what other things we could do to get health professionals, whether it's doctors, nurses, nurse practitioners, pharmacists -- you can go down the list -- to areas and have them stay in communities where we don't presently have health professionals that -- the number of health professionals that we need.

With regards to the nursing home issue, I hear you. I hear you. We have had the nursing home leadership in, we have sat down, I have addressed this with -- it's not just nursing homes, it's this issue, I think in the bigger picture of care, whether it's nursing home, home care, rehabilitative services. It's all the caregiving, it's all of this issue of how do we provide care for those who are either elderly or not even just elderly, just where they have a challenge that makes it difficult for them to be ambulatory or able to help themselves or have
relatives help them.

So we are looking at that. And I understand that this is a concern. I've heard it from all the legislators today. And I hear it on a regular basis. And we're trying to figure out a solution. If there was an easy solution to this, it would have been, you know, fixed a long time ago. So we are tackling it.

SENATOR RITCHIE: I appreciate that. And, you know, for me it makes it really concerning that the ones that had no problems a couple of years ago, that really were the stand-up institutions in the area, now are the ones calling saying "We can't make payroll." So something's got to be done.

COMMISSIONER ZUCKER: I know.

SENATOR RITCHIE: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Assembly.

CHAIRWOMAN WEINSTEIN: Assemblywoman Rosenthal.

ASSEMBLYWOMAN ROSENTHAL: Thank you,

Madam Chair.
Hello. I have a bunch of questions, so I'm going to ask quickly. 2019, a bill I passed into law requiring Department of Health to distribute a booklet about lymphedema to patients at high risk of developing it. It's been a year, and that hasn't been done. So please put that down on your list to do.

COMMISSIONER ZUCKER: Yup.

ASSEMBLYWOMAN ROSENTHAL: Secondly, I'm chair of the Committee on Alcoholism and Drug Abuse, and what I see in this year's proposed budget is shameful. People continue to die. People continue not to have access to Narcan, to buprenorphine, to any of those life-saving drugs that will keep people out of the streets to obtain drugs and will allow them to try to resume their lives.

Yet there are so many hurdles. The Governor vetoed a bill of mine eliminating prior authorization for people on Medicaid, yet he signed one on commercial prior authorization, eliminating that. You can quibble over provisions of the bill that
perhaps were not satisfactory, but the point remains that we have an opioid overdose crisis in this state, and it's shameful that we are not paying the attention that it deserves. Because it's about people's lives, and we are losing their lives.

So that's one statement.

One question for you is some years ago in the booklet End AIDS By 2020, there was a provision that the government supports the establishment of opioid overdose centers. Philadelphia has gone ahead, they've gone to court, they're still grappling in the courts, and we here in New York State, who pride ourselves on being first in the nation, are still quibbling about this issue.

This is a proven method of keeping people alive and helping them get to treatment if they are ready, and yet all we do is push out press releases about how we're making advances, but in fact we are not.

COMMISSIONER ZUCKER: So I'm glad you're bringing this up, because I think there's some points that you make that -- and
I want to just clarify, is that in 2019 is
the first year that New York State actually
has a decrease in the number of opioid
deaths. And we have made an incredible
effort on this issue. The Governor has had
in his -- the proposed new initiatives, in
addition to all that we've been doing. We've
got about half a million individuals in the
state who are trained to administer Narcan.
We have worked across the state on this.
I've heard stories about people who have
saved individuals.

ASSEMBLYWOMAN ROSENTHAL: Does
everybody who has an overdose and gets taken
to the hospital, once they're able to leave,
do they get Narcan or do they get
buprenorphine? Every single emergency room.

COMMISSIONER ZUCKER: So we've --
they've received Narcan at the hospital. But
we have worked at leading the nation on
trying to get buprenorphine into physicians'
offices so they don't have to actually go
to --

ASSEMBLYWOMAN ROSENTHAL: Trying to?
But what has happened?

COMMISSIONER ZUCKER: Well, we have pushed forward on this, and we have had -- we've led and got 24 other states to write to the federal government and sort of say that this is something that needs to be done, there's certain rules that have to be changed on that.

But we have banned, the Governor has banned the fentanyl analogs, we have addressed the medication-assisted treatment programs that are out there. I --

ASSEMBLYWOMAN ROSENTHAL: Wait, wait. Addressed?

COMMISSIONER ZUCKER: Well, I will tell you that what we have done is that we have established a buprenorphine prescription voucher -- I'll read through this program -- that provides a seven-day emergency supply of medication-assisted treatment as a bridge to insurance coverage. That's one of the things done.

We are connecting the emergency departments with doctors who can prescribe
buprenorphine through telehealth. That's the second thing we've done.

ASSEMBLYWOMAN ROSENTHAL: Wait. Is that in every emergency room where that's needed?

COMMISSIONER ZUCKER: We are moving towards that for every emergency room.

ASSEMBLYWOMAN ROSENTHAL: So when would that happen?

COMMISSIONER ZUCKER: We're moving -- these are some of the things that we want to do to move forward on this as the Governor's proposals for new initiatives this year on -- when it comes to this. We are working to propose a single formulary for Medicaid that will ensure access to MAT that will be granted quickly and efficiently. We are working with the correction facilities so that when someone leaves a correction facility, there isn't a -- there's a seamless transition of care. Often what happens is someone leaves and if they're not tied into the system, then --

ASSEMBLYWOMAN ROSENTHAL: I'm quite
familiar with that. And in the Governor's proposed budget, a million dollars was cut from money to the counties to actually implement that.

COMMISSIONER ZUCKER: But we are working -- we are working with the counties, we're working with the hospitals. Staten Island is one of the areas where there's been some of the challenges. We've been out there working with Staten Island. We're working across the system to address this.

On the Narcan issue --

ASSEMBLYWOMAN ROSENTHAL: It is too slow. People are dying. And we know some of the solutions to keeping people alive. And writing letters and demanding changes is all very well and good, but as the chair of the committee who deals with people and groups and advocates, it's like enough "trying to."

There are ways to implement and not try. Just do it.

COMMISSIONER ZUCKER: But we have -- we have implemented things --

ASSEMBLYWOMAN ROSENTHAL: No, no,
you've done some things, but there are so
many things that have not been done that
don't get enough attention in the budget.
And it's reprehensible that in New York State
we're allowing people to be homeless on the
streets, addicted to certain drugs, and not
have anywhere to go to make themselves
better.

CHAIRWOMAN WEINSTEIN: Thank -- thank
you. To the Senate.

CHAIRWOMAN KRUEGER: (Mic off.) We're
taking a leap it's another 45 minutes of
questions. Do you wish to have a human needs
break?

COMMISSIONER ZUCKER: I'm fine.
Donna, you good?

CHAIRWOMAN WEINSTEIN: Stretch your
legs?

CHAIRWOMAN KRUEGER: You're okay?

okay.

So actually, I'm up next. But you
turned down the chance to get out of the room
for a minute.

(Laughter.)
COMMISSIONER ZUCKER: What if we didn't come back?

(Laughter.)

CHAIRWOMAN KRUEGER: Well, there's the challenge. We have guards that wouldn't let you off the floor, not to worry.

(Laughter.)

CHAIRWOMAN KRUEGER: Sorry.

So actually Assemblymember Blake asked you about DSRIP issues. My understanding is that somewhere in the budget it actually says the three years we're still owed for federal money for DSRIP that localities, I'm assuming, already spent and are just waiting to get back to you, that there's some kind of taking back that money, and that the State Budget is wiping out your obligation to make good on the past DSRIP payments.

Do you see anything in the budget that says that?

MEDICAID DIRECTOR FRESCATORE: Yeah, that's not ringing a bell, Senator. I mean, there -- I'm happy to take a look. I apologize if I'm just not recognizing it.
It's localities and DSRIP, is that the concern? Or was it the enhanced federal match in the localities, perhaps?

CHAIRWOMAN KRUEGER: I don't know. So it was asked of me as a question, so I'm asking you to check for me --

MEDICAID DIRECTOR FRESCATORE: I will do that.

CHAIRWOMAN KRUEGER: -- whether there is previous years' federal money that we have yet to get that we believe up until now is owed to localities. And is there anything in this year's budget that changes that story line so, if and when the feds pay us, we're not paying it to the localities and the providers?

MEDICAID DIRECTOR FRESCATORE: Okay, I apologize, but it's just not ringing a bell. So we can talk about that. If you'll send us some more information, I'll be certain we look into it promptly.

CHAIRWOMAN KRUEGER: Thank you.

There was also some discussion about the Maximus contracts which we're all very
interested in learning more about. But I
wanted to point out, when we're talking about
the localities and their ability to impact or
not impact how much is being spent in
Medicaid and eligibility, in New York City
it's Maximus that decides how many hours
you're going to get in long-term care. Yes,
they determine the number of hours. After
you're approved for Medicaid, then you go to
the Maximus and they determine the estimated
number of hours. Then it goes to the care
provider, who can argue it.

But so, again, how is it the locality
controlling this?

MEDICAID DIRECTOR FRESCATORE: Yeah,
so let me explain how the process works. So
an individual, say, for example, a person
who's eligible for Medicare and Medicaid, a
dual-eligible, say they're not in Medicaid
currently but they have a healthcare episode
that requires that they're going to need some
home care.

They would go to their local district,
and they would apply for Medicaid. They
would have to have, under regulation, a
doctor's order that says they need help in
their home, particularly, you know, with
activities of daily living. And the local
district would do a nursing assessment and a
social assessment. And based on the
results -- and that's what's in regulation --
based on the results, the local district
would develop a plan of care for that
individual.

Conversely, if that individual was
already in a managed-care plan at the time
they developed need for long-term-care
services, their service plan would be
developed by the managed-care plan.

Maximus doesn't develop or decide a
number of hours. There is a conflict-free
process that Maximus administers, sometimes
referred to as CFEEC, is the acronym you'll
hear. That process is not setting the care
plan. It is -- it's a determination that the
individual is in fact meeting the threshold
need for long-term care, which is 120 days of
continuous home care services.
So Maximus does not determine Medicaid eligibility, they don't decide who is eligible and who is not, and they don't develop the care plan once someone is determined to need long-term care.

And I know it's different avenues depending on where people start off.

CHAIRWOMAN KRUEGER: I understand -- right. The county decides if you're eligible, there's no eligibility options for the counties, it's the state's rules.

And then at least for the city, which used the majority of long-term-care dollars, I believe, it goes through Maximus to determine whether or not you're going to be eligible.

MEDICAID DIRECTOR FRESCATORE: No, in fact when we look at the statistics from current data, what we see -- and I had given the statewide statistics earlier, about 400,000 people in New York City are receiving either personal care or consumer-directed care. And the care plans and number of hours for those individuals are determined by the
Health Resources Administration. That is a
duty of the local social services district
for the people who are in fee-for-service.

CHAIRWOMAN KRUEGER: So in the MRT, which has also been brought up a number of
times, and concerns about that, the Governor announced there will be two people
cochairing, I guess. One is the retired head
of 1199, and one is the current head of the
largest hospital system in the State of
New York.

Do you find it to be a conflict of
interest for the person who's the head of the
largest hospital system in the State of
New York to be the one deciding where
Medicaid cuts are going to go or not go?

COMMISSIONER ZUCKER: Well, I'll
respond and say that I believe that -- that
they can separate their interests of --
their -- well, you're specifically focusing
on the hospital system -- separate their
interests that -- from the system that
they're doing and then look at the issue, the
bigger picture of Medicaid reform.
CHAIRWOMAN KRUEGER: Hmm. I would assume they have a contract that makes them be fiduciarily responsible to the best interests of their healthcare system. Not having seen the contract.

COMMISSIONER ZUCKER: Well, they're the chairs, and there will be a whole committee. And I'm sure that a lot of people will provide their input as well. And I think that the -- what will come out of that MRT II will be a way forward. And I think that the chairs will help oversee that, but there will be a lot of input from many others.

CHAIRWOMAN KRUEGER: So even though that MRT hasn't gone to work yet, and we don't know who else is on it -- because Senator Rivera already raised that with you -- there are some specific cuts in this budget to MRT changes that have been in effect in New York State. The one I want to highlight is the Department of Health is cutting the MRT supportive housing program from 98 million to 26.7 million.
That has sort of been a star program, as far as I've ever seen in the reports, that we actually got medically vulnerable and sick people into housing from the streets and we radically reduced their use of Medicaid and other healthcare funding.

So we're potentially going to translate this into up to 1500 disabled people who were homeless and were high users of Medicaid -- substance abusers, HIV/AIDS, chronic health issues, mentally ill -- and put them back on the streets, even though we didn't have MRT meeting yet again. Why is that specific cut in the budget?

MEDICAID DIRECTOR FRESCATORE: So let me see if I can address this.

So the current-year actions for '20 include $3 million for supportive housing that is unspent. It's not committed. That funding is -- it will remain -- it's unspent money.

I know there's been some confusion about the appropriations and the complexities of how they work between the state funding
and the federal funding. But it is from the
Medicaid global cap standpoint. It is our
intent to have the cap continue to fund every
unit, every subsidy that's currently being
funded.

And if you look in the April through
December Medicaid Global Spending Report when
we forecast spending, you'll see that part of
the spending forecast under the global cap
includes the commitment to supportive
housing.

But I'll go back and see if I can get
some clarification, because I think the
appropriations structure -- that they can get
complicated. And I -- but it is -- again,
the Medicaid global cap is going to support
every unit subsidy that's supported
currently, with the exception of what's not
spent, and that's $3 million.

CHAIRWOMAN KRUEGER: And because I
want to make sure I heard you correctly
before, Director Frescatore, I believe you
answered a question when someone said if a
county goes over the cap, will they lose a
percentage of the Medicaid growth money from
the state? Will they lose all the Medicaid
growth money from the state? I believe you
answered, though, they'd lose all of it.

MEDICAID DIRECTOR FRESCATORE: It
depends on whether or not they've met the
property tax cap. If they live within the
property tax cap, and let's say, for example,
the Medicaid spending growth is 4 percent and
the allowable percentage is 3 percent, they
would be responsible for the 1 percent
differential.

If they came in at 2 percent, that's
where the sharing would occur, 25 percent of
the difference there.

CHAIRWOMAN KRUEGER: So we're asking
the counties, live within your property tax
cap, pick up additional costs in Medicaid,
but if you're not successful in magically
figuring out how to do it without going above
cap, we're going to take a bigger chunk of
money away from you.

MEDICAID DIRECTOR FRESCATORE: I think
that what the proposal does is it looks to
bring the local districts to the table in
working with all of us to find effective ways
to control the growth of the Medicaid
spending. And I'm confident we can find
those partnerships.

And there's lots of good ideals out
there, I believe, at the local level because
they are on the ground, that will allow us to
work in that partnership.

CHAIRWOMAN KRUEGER: My time is up,

thank you. Assembly.

CHAIRWOMAN WEINSTEIN: Assemblyman

Ashby.

ASSEMBLYMAN ASHBY: Thank you,

Madam Chair. Good afternoon, Commissioner,

Director.

Being that our counties are
intrinsically tied to Medicaid through
coordination of services, delivery of
services and funding, and our growing aging
population of all races and ethnicities is
growing tremendously as a primary population
using Medicaid, why wouldn't our counties and
long-term care have reps on MRT II? And
don't you think their inclusion could help prevent an MRT III?

MEDICAID DIRECTOR FRESCATORE: My recollection is that in fact there was county representation on the first round of MRT. I've certainly talked to the folks that -- our local social services commissioners or county social services commissioners. They expressed their interest as well. We'll have more information later.

But again, you know, the intent of the MRT is for the representation to be statewide, for it to include legislative representatives, as it did the first time, and for it to, you know, be very broad in its stakeholder perspective. So every sector of the healthcare industry as well as local governments.

ASSEMBLYMAN ASHBY: So why wouldn't we see representation on MRT II right now from the counties and long-term care?

MEDICAID DIRECTOR FRESCATORE: MRT II has not been convened yet.

ASSEMBLYMAN ASHBY: Why wouldn't these
people be on it? Can you think of a reason?

MEDICAID DIRECTOR FRESCATORE: I --

we'll have -- there will be more information

later in this week. But what I'm saying is

that in the past they were on it, and --

ASSEMBLYMAN ASHBY: So there's no good

reason why we should expect they wouldn't be

on it this time. Is that fair to say?

MEDICAID DIRECTOR FRESCATORE: I --

I -- I'm not aware of any decision they would

not be part of it.

ASSEMBLYMAN ASHBY: Okay. Thank you.

COMMISSIONER ZUCKER: I think I would

say that the feedback that we have heard from

all of you is helpful as we develop the

MRT II. And I know Senator Rivera was asking

about, like, the composition. But we've sat

here for several hours and heard the -- your

concerns and interests of who should serve on

such a committee, and that's very helpful for

all of us.

CHAIRWOMAN WEINSTEIN: Senate.

CHAIRWOMAN KRUEGER: Thank you. We're

just double-checking.
Okay, to close for the Senate, second round, Gustavo Rivera, chair of Health.

SENATOR RIVERA: Round two. It's going to be a quick one.

First of all, this is the Medicaid Global Spending Cap Report, April through December of 2019. Could you explain to us in a very tight nutshell why it took nine months for what is supposed to be a monthly report to be produced?

MEDICAID DIRECTOR FRESCATORE: The intent of the report is to present the proposed solutions to close any structural deficit, and those solutions are reflected in this report consistent with the --

SENATOR RIVERA: That's not what I asked. I'm sorry, not what I asked. I said why did it take nine months to produce a report which should have been produced on a monthly basis from March to here?

MEDICAID DIRECTOR FRESCATORE: And my answer was that the purpose of the report, we believe, is to present the solution -- if a structural deficit is identified, to present
a solution. And it was when the solution was
identified that the report was produced.

Every month's information is contained
in the appendix.

SENATOR RIVERA: That's not an answer
to my question, but okay. Because you could
have put it out on a monthly basis. You're
telling us that you basically had no
information for nine months, but at the
nine-month level then you figured out that
you could put together nine months. That's
not an acceptable answer. That's number one.

Number two, the Governor said that
there were no cuts. That's what he said
during his budget presentation. And could
you tell us what the reduction and
consolidation of the rural health funding,
the discontinuing of the Health Workforce
Retaining Program, the discontinuing of the
Diversity in Medicine, the discontinuing of
workforce studies, and particularly just as
one particular one, the discontinuing of the
Adult Cystic Fibrosis Assistance Program,
which serves 70 individuals, seven-oh, and
saved the state $380,000?

I mention all that to say how can you
make the argument to me that those are not
cuts? That's number one. And number two, if
we're trying to close a $2.5 billion hole, is
it not a little silly to sit here and tell us
that we're going to take away something from
70 people that have cystic fibrosis to save
$380,000?

COMMISSIONER ZUCKER: So I think as I
mentioned before, it's challenging fiscal
times, and we're trying to figure out how to
make -- move forward and be a little bit more
efficient. I hear you about the cystic
fibrosis issue. And figure out other ways to
make sure we're able to provide some of the
services for those individuals that --

SENATOR RIVERA: And this is on top of
the fact that this is the stuff that is for
2021, right, the stuff that you did -- this
is stuff that you're proposing for now.

And also we talked about earlier about
the fees for -- children's camp permit fee,
asbestos safety program certificate,
Certificate of Need fees, which give us $680,700. It just seems to me like this is all a pittance in the big scheme of things, and that we should be looking elsewhere, particularly on taxing the wealthy. But we're going to have a whole conversation about that another time.

For you folks, I've got two more. First, the -- as it relates to both of those things, so if you are asking us to say that -- there were a bunch of people that brought up -- there was the Maximus contracts that were brought up. The fact that there was a very clear statement that said that there were no cuts, when there obviously are. The MRT conversation that we've had over and over again, which says -- you provide no details about anything. And then you also, as it relates to this -- what we're trying to figure out is how it is driving the cost, right? I will admit to you that I am not as smart as many of the folks that we have in our central staff. And our central staff have been talking to your central staff and
asking very specific, pointed questions so we can have a better understanding of what exactly is driving costs. Tell us where it is, right, and the exact information -- you seem to have the numbers, but you can't tell us where they come from. And they're asking you better questions than ever I could, and you're not giving it to them.

So all of this, this is what I want to get to. And I want to make sure this is very, very clear. Whether it's on the MRT, whether it's on the Maximus contract, whether it's on the suggestion that there are no cuts when there obviously are -- what you're asking us to do as a Legislature is to trust you. Folks, this don't build trust. I will only speak for myself in this moment, but I figure many of my colleagues can agree: We don't trust you. You gotta build that. This ain't helping.

And the last thing that I'll say, in the last 50 seconds, is one other thing that just -- as if we didn't have enough stuff to deal with, and this is something that is
bigger, the public charge rule that was just implemented, right, the Supreme Court decision just a couple of days ago -- it was literally a day ago. We've really got to get into that. We've really got to get into that, because that could have a potential impact of $7 billion, according to some analyses. And if we're already in this mess and you're not being honest with us -- we've got to fix this together. You've got to build trust to do that. This don't do it. The hours that we've spent here does not do it. And you know I like you folks. But I'm not going to be -- I'm not going to sit here and not say that all this fighting that we're doing is because we know the impact that it has in our communities back home.

We've got to fix this together, we've got to do it by building trust. We don't trust you. You've got to make us trust you. This does not help.

Thank you, Madam Chairwoman.

CHAIRWOMAN WEINSTEIN: Thank you. We go to Assemblywoman Solages.
ASSEMBLYWOMAN SOLAGES: Hi, good afternoon. Thank you, Chairwoman.

I'm not going to belabor the point about the MRT or the MRT II, because as you know, New Yorkers pay some of the highest property taxes. So any cost shift is really going to affect our bread-and-butter families, and any cuts is going to affect our most vulnerable. So I'm going to leave that to you.

So I just want to move on to birth workers. Birth workers. So the other day, or last year, New York State launched a pilot for doula care. And it was very exciting. I know in Erie County the pilot has been initiated and it's currently -- the findings are happening.

However, in Kings County, I hear that the pilot hasn't even gotten off the ground. So can you give us a status update regarding the doula pilot?

COMMISSIONER ZUCKER: I'll get you the details on where it is in Kings County. I know that this was a discussion, it's just
slipping my mind on where we are on that. I know that that was -- that it has started in other parts of the state.

ASSEMBLYWOMAN SOLAGES: Yes, many of the doulas are upset because you know, obviously, they cannot work for free. And I know the state was proposing a fee that wasn't realistic to the amount of visits that are needed.

So you made a mention that you're committed to, you know, reducing mortality and morbidity --

COMMISSIONER ZUCKER: Maternal mortality.

ASSEMBLYWOMAN SOLAGES: And so I hope that there can come accord, because this pilot was announced, you know, probably a year or two ago, and we're still sitting here not having a pilot in Kings County.

COMMISSIONER ZUCKER: Let me look into that.

ASSEMBLYWOMAN SOLAGES: Thank you.

COMMISSIONER ZUCKER: My data is not up to -- I know this from a couple of months
ago, but I'd rather answer you with the most recent data.

ASSEMBLYWOMAN SOLAGES: I look forward to it.

So I want to just go back to the Commodity Supplemental Food Program. As you know, there was a cut and many seniors on Long Island were left with, you know, not having access to food. And we know that there's a high risk between food insecurity and what's going on with seniors.

So can you give us simply a status update about what's going to happen after this emergency stopgap measure is done?

COMMISSIONER ZUCKER: So we are looking at other ways to provide funding for that -- and some emergency contracts, transition those seniors to other food access programs. So we recognize that. And Senator Kaminsky raised that with me, or with all of us, a little while ago about that whole issue, about the access to food for seniors.

So we will figure that out. And we're
working on a longer-term plan because it's not -- we recognize that just a stopgap measure won't solve the problem.

ASSEMBLYWOMAN SOLAGES: Correct. Is there any moneys that were put in the budget to help alleviate this issue forthcoming? Because the contract is not going to be renewed, or an RFP is not going to go out until four years from now. So what's going to happen in between now and --

COMMISSIONER ZUCKER: We'll look for what kind of emergency contract we could put into place. But let me -- let me figure out a little bit -- let me get back to you about the specifics of how we can make sure there isn't a gap there for those individuals.

ASSEMBLYWOMAN SOLAGES: Okay. And what is the Department of Health doing to prevent such -- I know that there was an issue with one of the contractors not facilitating or opting in, and no one from Long Island actually went and bid for the contract. And so Long Island was left not having a service provider.
So what is the Department of Health doing to prevent that from ever happening again?

COMMISSIONER ZUCKER: Right. So that's exactly correct, that someone did not bid. And we were not in the place to be able to say to them, Well, you didn't bid, because that's -- it's a competitive procurement process, so we couldn't say anything until we issued the contract. So that put them in a difficult situation, obviously.

So I think the lesson learned from there is, going forward, to figure out is there any way to make sure people are aware that this is not so much a contract but that there is a -- something put out for bid ahead of time. And maybe the answer is -- and I have to figure this out, whether to, you know, go to the legislators and say this is something that your community is -- has had in the past, and is there a way to make sure that you're aware that that program is coming to an end.

I don't know if that's legally
allowed, so I have to figure out what's legally allowed. But I recognize what you're saying, is how do we make sure that it doesn't happen again that there -- whether it's in Long Island or elsewhere, that there is a gap because something didn't get processed at the right time.

ASSEMBLYWOMAN SOLAGES: Many seniors on Long Island are relying on a solution.

COMMISSIONER ZUCKER: I know. I know.

ASSEMBLYWOMAN SOLAGES: And so we need to come to the table and figure this out.

COMMISSIONER ZUCKER: I hear you. I hear you.

ASSEMBLYWOMAN SOLAGES: People can't go hungry in New York State.

COMMISSIONER ZUCKER: I hear you. And they won't.

ASSEMBLYWOMAN SOLAGES: Thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

Senate?

CHAIRWOMAN KRUEGER: I think we're done. Keep going.

CHAIRWOMAN WEINSTEIN: Assemblyman
Salka.

ASSEMBLYMAN SALKA: First of all, thank you, Doctor. Thank you, Director. Your testimony has been very informative. And having spent 32 years on both the clinical and the managing side of medicine, I'm sure we can agree it's changed quite a bit. We have the miracle of modern medicine, but that miracle comes with very, very high costs. Nonetheless, if it's saving lives, then that's worth every penny of it.

I just want to reiterate what some of my colleagues have said about emergency medical services and just the stress that in upstate New York emergency medical services right now are at a critical junction. A lot of them are looking at maybe a year at most of being able to provide services. And in rural areas, it's very, very important, obviously, just like any other urban area.

Also, we're looking at a critical shortage of providers in upstate New York. I was the director of a cardiac lab, and believe me, we had a near impossible time
trying to find a cardiologist. So again, I would hope that you give that the highest of priorities.

One question -- I see that we're doing a bit of a root cause analysis here. One question I have is that when the Affordable Care Act was incorporated, was initiated, it came with the promise of certain subsidies because we knew that the states were going to increase their numbers -- sometimes almost near exponentially -- quite a bit. And I'm sure that happened in New York.

Have those subsidies kept up with the increased enrollment? And if they haven't, shouldn't we be lobbying our federal representatives too to be able to take care of any shortfalls in funding that we should be getting for Medicaid subsidies in New York State?

MEDICAID DIRECTOR FRESCATORE: Yeah, I'm happy to try to address that.

So the Affordable Care Act did in fact include higher levels of federal match subsidies, in effect, for certain
individuals. New York had been one of, you know, five or so states that had gone ahead and extended, through state law, coverage to childless adults. And so the expansion group here in New York wasn't large compared to some other states, and we continue to get nearly 100 percent federal match for the new enrollment, the expansion group, which is about 220,000 people. It's relatively small in the context of the 6 million people.

You know, I think that, to answer your question, yes. I mean, given we've made tremendous progress here in insuring people, and we think insurance is the gateway into being able to access care, and access to care lets us build providers and communities throughout the state. The upstate counties have had tremendous growth in coverage rates, I mean, quite impressive, and we commend them, particularly the community groups that get out there and help spread the word about the availability of the coverage.

But, you know, I think given the opportunity, there are some parts of the
Affordable Care Act that we clearly would like to see changed federally. The match rates are one of them. There are a couple of other places where we think that the coverage could be structured if we were given the chance to make that case, so that there was less out-of-pocket costs for people.

So we always look for those opportunities. We've been very -- you know, as Senator Rivera mentioned, the public charge rule, I think that, you know, that these are individuals who are entitled under federal law for coverage. And that certainly it's frightening to people to come forward and get coverage if you think that your path or your family's path to citizenship could be in jeopardy by doing that. That's one of the reasons we -- the Supreme Court decision, one of the reasons we extended our open enrollment period by a week.

So yes, I mean I think that given the opportunity, we would look for more Medicaid support. Unfortunately, what we're seeing, perhaps as soon as tomorrow, is the ability
for states to go in to the federal government
under a waiver and ask for block grants, so
that they can cover fewer people or give, you
know, people fewer benefits. Which just puts
additional costs on the healthcare delivery
system, in our view.

ASSEMBLYMAN SALKA: Thank you. Thank
you for your answer.

MEDICAID DIRECTOR FRESCATORE: Long
answer, I apologize.

ASSEMBLYMAN SALKA: Oh, that's fine.
That's fine. It was a good answer, thank
you.

CHAIRWOMAN KRUEGER: Okay, another
Assemblymember.

CHAIRWOMAN WEINSTEIN: Yes. We go to
Assemblyman Abinanti.

ASSEMBLYMAN ABINANTI: Thank you both
for joining us today. The ordeal is almost
over, but not quite yet.

I think the reality of the budget does
not match the rhetoric that we've heard that
New York actually cares about its citizens.
I think what we have before us is in general
an overly complicated proposal which is not serious, but is designed to divert attention from the fact that the entire approach is to cut state costs, no matter what the cost to people, and to shift the blame to somebody else -- to an MRT, to our counties, to the outside contractors.

You keep talking about we're looking for efficiencies and savings. You've had 10 years to come up with efficiencies and savings. This administration has been in charge for 10 years. And we're going to solve all these problems, which you see as challenges, in the space of a few weeks with another group of people coming together.

Number one, on the MRT. You've always said it's a success. To the people who use New York State services, it's a failure. They're not getting the services they need. I speak particularly for the people with developmental disabilities. They can't find services. They're not there. The help they get is inadequate.

So I'm hopeful that when you put
together this MRT II, you put on that a consumer to match every industry group that sits on that board -- some consumer advocacy group that's going to speak for those who seek the services and use the services, not just those who deliver the services. And I'd like to see them appointed by the Speaker and the Majority Leader, not by the Governor's office.

Secondly, you talk about involving the counties again. Medicaid is a state responsibility, not a county responsibility. We're the only state in the country that asks our counties to contribute as much as they do. I believe they have a role in contributing some money, but they do not have the power to determine what services people get.

Let's talk about people with special needs. It's OPWDD that determines how many hours somebody gets, not the County of Westchester or any one of our counties.

So what we're doing is asking the counties to share the blame for knocking
people off and not getting services, so that
the state can say they care about people.
And if the counties actually do have to pick
up more of the cost, you're destroying their
budgets. They're going to have to cut back
on roads, they're going to have to cut back
on all of their other services, because they
want to stay within the property tax cap.
Because there are disastrous results if they
don't.

Now, you talk about they could look to
the assets. Well, we already impoverish
people to get Medicaid. If you're a person
with a disability, you have to meet a
spend-down: $859 for a person in Westchester
County. You can't live on $859. You can't
even be in an apartment. And so by having
such a low level for spend-down -- and you're
suggesting that the counties look for more
assets, as if these are rich people who are
hiding their assets just to get services.
It's not going to work. You're just shifting
the blame to the counties and creating more
problems.
Now let's talk about the deficit for a moment, point three. This is a self-created crisis. As I'm understanding it, you shifted $2 billion from last year's budget into this year's budget. You did nothing about the spending last year, so you're going to have another $2 billion deficit because you're spending the way you were spending last time.

And you're including more every year in your Medicaid column that used to be in other columns. This year you've shifted a billion dollars for OPWDD from the spending column there to the Medicaid spending column. You've been paying for it through Medicaid all along, so I'm not talking about where the monies are coming from in. I'm talking about where you're showing them in the budget. The whole thing is a big charade. So that's a billion dollars more that you're going to be, quote, spending on Medicaid that used to be in a different column somewhere else. So you bump up against the 3 percent level because you don't want to spend the money to help the people who need the help.
You rolled over the $2 billion --
there was no shortage of cash; you could have
paid for it. You rolled it over because you
didn't want to exceed the arbitrary 3 percent
cap. You've inflated the over -- the
spending, as I just noted, from basically
just budgetary acrobatics, to make the
problem look bigger, and then you're a victim
of your own success.

You have privatized Medicaid. When
you privatize it, you've asked the private
sector and the not-for-profit sector to go
out and pick up people and put them into the
plans. Well, they've been successful at
doing that.

I'd like to hear from you how much it
costs for administration versus what it used
to cost for administration, and how much is
actually going to direct services for people
versus what it used to be. You're now paying
all of these managed-care plans for their
administration. They get a per capita or
whatever. They've got to go out and sign
people up.
But the people are not getting the services. Okay, they may be part of the plans, but they're not getting the services. And I think this is a faulty strategy to privatize it. And we've had people talk about other contracts, the Maximus, et cetera.

And lastly, I just want to -- and this is maybe where I'll ask you the question. Where did you come up with 3 percent? You're using the 3 percent cap and saying there's a deficit because we can't keep our spending within the 3 percent, even though you admit that there's been a huge increase in the needy population who need the services.

So why are we sticking to a 3 percent cap? Where did that come from, where did that become the magic number? It's not a shortage of money and cash to pay for services. It's just that you have said we're going to stay at a 3 percent, if we're over 3 percent we've got a deficit. Where did you come up with the 3 percent?

And the second question is, are you
still pushing managed care for people with
developmental disabilities? Last year you
had money in the budget to at least help the
transition. There's no money in the budget
for the transition. Did you spend the
$5 million from last year? And what are you
going to do this year?

So it's two questions, really, the
basis for the evaluation of 3 percent and the
managed care for people with developmental
disabilities.

CHAIRWOMAN WEINSTEIN: So maybe you
can answer those offline -- or unless you
have a quick response.

MEDICAID DIRECTOR FRESCATORE: If I
could, Assemblyman, the basis for the
3 percent is in state law, and 3 percent is
the math on the rolling 10-year average of
the Consumer Price Index.

ASSEMBLYMAN ABINANTI: Oh, I'm aware
of that. But it was put in there because the
administration wanted it.

CHAIRWOMAN WEINSTEIN: Assemblyman,
that's -- Assemblyman, the time has expired.
Thank you.

We'll move on to Assemblyman Palmesano.

ASSEMBLYMAN PALMESANO: Yes, thank you. I have a couple of questions.

Before I do, I notice there's some emergency service workers in the audience, and I just want to say -- I'm sure I speak for everyone -- thank you for what you do each and every day to keep our communities safe and saving lives. And given the impact that the budgets -- Medicaid has on them, they should probably have a seat at the table as well.

But I wanted to go back to the question relative to the expansion of the Affordable Care Act or Obamacare, however you want to refer to it. I think it happened around 2014. And the big -- everyone praised it, everyone said, Well, because the feds are going to pay for it, they're going to pay a hundred percent at the beginning, and then it's going down to 90 percent. Billions of dollars to expand.
And I guess it's around 90 percent now, but nothing keeps it there permanently. They can drop it at any time given their fiscal situation, which would create a big shift to us.

And I want to ask these questions first to get them out before I forfeit my time.

So what's to stop that, if that is dropped? And that's more that's going to be put back onto the state and also going to be shifted. So everyone praised this, but there's fiscal implications to this as well.

Another thing that really aggravates me about this budget and the Governor's proposals, I think -- can you guys, can you both list specifically what counties can do to cut Medicaid costs and growth? Because we already determined, we know that eligibility expansion, those guidelines are established by the federal government and the state government, not the counties. The counties just follow the requirements that are given to them and pay the bill.
If there's program expansion, like the Affordable Care Act, expansion of that, that was determined by the state, not by the counties. The 30-plus optional Medicaid programs that we have, those were determined by the state, not the counties. They didn't opt into that. They just are given a bill to say "Pay it." And the Governor says and the Budget Director says counties have to have skin in the game. They do have skin in the game. They pay $8 billion now. So they already have skin in the game.

So where are they supposed to cut? Are they supposed to cut services to the seniors and the disabled, for long term care and nursing home care? Are they just supposed to put those people back out on the street? Where are they supposed to cut and what can they do?

And listen, quite frankly, if the Governor wants to say locals need to pay more, the property tax payers need to pay more, then he should just say it. But he's already got it planned in his budget to the
tune of $150 million a year. But it's completely disingenuous, an insult and false for him to say counties have absolutely any say or control on the cost or growth in the Medicaid program. He knows that, you know that.

And quite frankly, when you talk about staying within the property tax cap, how are they supposed to stay within the property tax cap when you have this cost shift of Medicaid that's going to happen, not to mention other cost shifts that are affecting county budgets with the so-called criminal justice reform, bail reform, discovery requirements that are shifting incredible costs to those counties?

So how are they supposed to stay under the property tax cap with the challenges they're facing now? And then on top of it, this Medicaid shift, that's going to be more than the property tax. They can't do it. It's wrong.

And I just -- so those are the points I want you to address. One, about ACA, if there's changes in the reimbursement, we're
on the hook for that. That's going to get
shifted -- if that gets shifted as well,
that's going to drive up costs. There's no
guarantee with the federal fiscal situation.

And two, what specific programs can
the counties do, because they have no control
over eligibility, they have no control over
program expansion, they just implement what's
given to them. And now the Governor and you
are saying "You need to pay more," to the
tune of at least $150 million which he's
already budgeted for. It's disingenuous and
wrong.

MEDICAID DIRECTOR FRESCATORE: So let
me start with your question about the federal
support for Medicaid.

So, you know, we look at the different
sources, different types and categories of
covered individuals in Medicaid: 4.9 million
of the 6.2 million are the traditional
Medicaid program. Those are in the rules
where the match rates for New York are about
50 percent -- 50 percent federal money, the
other 50 percent non-federal share, as we
call it. So some combination of state and
local.

The expansion that the state did
before the Affordable Care Act is about
1.2 million people. The federal government
pays 75 percent of the cost of those
individuals. With the Medicaid expansion,
that's specifically in your child -- adults
without children, between 100 and 138 percent
of the federal poverty level, 220,000 people,
the federal government pays 100 percent.
That -- those are in law, those are in
federal law. If your question is could
Congress change that, I suppose that is
possible. But this is based on what is
currently in federal law, and the law would
need, you know, to be changed. So that's
kind of how the shares break out. It's
dpending on people.

To get to your second question, I
think we've talked about this, you know,
several times throughout the course of the
morning here, and early afternoon. Local
districts play some important roles in
day-to-day administration of the program. We believe that -- I believe that they are closest on the ground, they see what happens in their local districts, and that they can partner with us in finding ways to reduce and bring -- you know, to rein in the growth in costs. And I can tell you I talk to districts from time to time who say, Jeez, you know, what if we did this.

The two places where the local districts have a role, again, they process 47 percent of the total Medicaid applications. So 47 percent of 6.2 million have their determinations made by the local district, the county, generally, in which they reside. And they play a role, as I mentioned before, in approval of certain services; in particular, long-term-care services, personal care, consumer-directed care, and some other services that have costs on the fee-for-service side of billions of dollars a month.

And so we want to partner with them, we want them to come to the table in a way to
work with us and all of you to address the
escalation in costs so this program is
sustainable for everyone.

ASSEMBLYMAN PALMESANO: So partner
with them, don't punish them.

CHAIRWOMAN WEINSTEIN: We go now to
our chair of Health for his second round,
Assemblyman Gottfried.

ASSEMBLYMAN GOTTFRIED: Okay, I have
a few questions which are I think short and
can hopefully be answered pretty briefly.

One is to clarify. Is it within the
jurisdiction of the MRT II, if it chooses to,
to consider and propose changing the cap, the
global cap, and what gets treated under the
cap and not? And secondly, closely related
to that, can it consider tax proposals?

COMMISSIONER ZUCKER: I can't answer
that question right now until we sit down
with the MRT II team. But I will get back to
you about those two.

Donna?

MEDICAID DIRECTOR FRESCATORE: Yeah, I
think, you know, I -- I think I might add
that we won't know for certain until this --
till more has started about the process.

But while I -- again, we look at the
cap as a tool for us all to measure, I think
there is openness for --

ASSEMBLYMAN GOTTFRIED: Yeah, I
understand the merits or demerits of the cap.

MEDICAID DIRECTOR FRESCATORE: There's
openness of the metric that's used. It would
be -- it's an open decision --

ASSEMBLYMAN GOTTFRIED: We're trying
to keep the answers brief. I wasn't asking
whether the cap is a good idea. I was asking
whether the MRT II will be barred from
thinking, from proposing things about
changing the cap. And the answer is you
don't know yet. Okay.

The Assembly has been asking for
county-by-county local share spending
numbers. I'm sure you have that data. Can
you send it to me and to Ways and Means by
tomorrow?

MEDICAID DIRECTOR FRESCATORE: I will
confirm whether we can send it by tomorrow or
not. The --

ASSEMBLYMAN GOTTFRIED: And could you
speak into the microphone?

MEDICAID DIRECTOR FRESCATORE: Yeah,
we will confirm whether we can send that to
you by tomorrow or not.

But the April through December report
has some information that's county by county
in it. I think that might be of help. But
we'll get back to you later today or in the
morning.

ASSEMBLYMAN GOTTFRIED: Okay. Because
apparently what we've been getting is the
increase in the -- in what the state is
picking up of what used to be paid by each
county. But what we want to know is what
each county is currently spending. And I'm
quite certain you have that. And I'm quite
certain there is a DOH employee who could, at
the push of a button, send me that table.

So I'd appreciate it if they would --
if you would find that employee and tell them
to do that.

Similarly, the monthly global cap data
that has been asked about. I'm sure that in
an enterprise the size of DOH there is
somebody who can, on their computer, see that
number daily. And the fact that it's not
being generated monthly may be why
Mr. Mujica, in a New York Times story about
how surprised everyone was about the spending
going so wildly over the global cap, why
Mr. Mujica said that he didn't know that that
was happening. Which was, I think, kind of
striking to a lot of people.

So my question is, could you resume
generating that data on a monthly basis and
send it to me and Mr. Mujica?

MEDICAID DIRECTOR FRESCATORE: It's
our intention to generate reports on a
monthly basis.

ASSEMBLYMAN GOTTFRIED: Excuse me?

MEDICAID DIRECTOR FRESCATORE: It is
our -- it's our intent going forward to
generate those reports on a monthly basis.

ASSEMBLYMAN GOTTFRIED: And to send
them to us like right away, as they're
generated.
MEDICAID DIRECTOR FRESCATORE: Yeah, they're public reports, so I think as soon as they're generated and we do our quality assurance, they're available publicly.

ASSEMBLYMAN GOTTFRIED: Well, okay. Unfortunately, for the Health Department to say something is public data doesn't mean I can see it, given the rate at which the department responds to FOIL requests.

MEDICAID DIRECTOR FRESCATORE: We -- we -- I wasn't clear. We post them on the website.

ASSEMBLYMAN GOTTFRIED: The monthly global cap data?

MEDICAID DIRECTOR FRESCATORE: The monthly global cap reports.

ASSEMBLYMAN GOTTFRIED: Are posted monthly?

MEDICAID DIRECTOR FRESCATORE: Well, we had -- as we talked about earlier, there was a period of time where they were not available. But our intent going forward is to produce these reports monthly, and they are posted on the DOH website. We can get
that site, you know, for everybody if that's helpful, the link.

ASSEMBLYMAN GOTTFRIED: You mean they will be posted. And with how much lag after the month involved?

MEDICAID DIRECTOR FRESCATORE: You know, we need to let all the data for the month complete, and -- so I don't know. We can -- I can give you a best estimate of that. But I need to talk to our analysts who work with those data sets all the time to give you an accurate expectation.

ASSEMBLYMAN GOTTFRIED: Okay. Earlier you were saying what -- on the question of what role the counties play in determining eligibility for care, and you talked about the local social services districts determining some huge amount of home care eligibility.

As I understand it, the localities make that determination for fee-for-service, which is to say less than 120 days home care, but that 90 percent, roughly, of home care is long-term home care, over 120 days, and
that's not determined by the county, it's
determined by some combination of Maximus and
managed long term care plans. Do I have that
right?

MEDICAID DIRECTOR FRESCATORE: Well,
partially. But there's also people who are
in -- who receive long-term-care services who
are not required to join a managed-long-term-
care plan. So individuals that are not
dually eligible are not required, so those
individuals would remain in fee-for-service,
as well as some other individuals that are
exempt from having to join a managed-care
plan, and their care plan would continue to
be developed and their six-month reassessment
done by the local district.

So the numbers I gave you are for
people in fee-for-service.

ASSEMBLYMAN GOTTFRIED: But about
90 percent of home care, as I understand it,
is in fact required by law to be done through
a managed long term care plan.

MEDICAID DIRECTOR FRESCATORE: What's
required by law is who has to join a managed
care plan, not how much home care has to be
in the plan.

And when we look at the data, what we
see is that state -- that statewide, there
are 907,000 -- that's the number I cited
before -- individuals who are in
fee-for-service who receive either personal
care or consumer-directed care where their
care planning would be done by the local
district.

It's about 34 percent of people who
receive those services statewide, with the
remaining 66 percent getting those services
and the care planning done by their managed
care organization.

ASSEMBLYMAN GOTTFRIED: Okay, I --
CHAIRWOMAN WEINSTEIN: Thank you.
ASSEMBLYMAN GOTTFRIED: I assume you
have -- just I assume you have a document
that says how much money is spent on
long-term care through MLTCs and how much is
spent through fee-for-service. I'd like to
see that data.

MEDICAID DIRECTOR FRESCATORE: Okay,
let me -- I don't have that with me. Let me
see if we can't get that to you.

CHAIRWOMAN WEINSTEIN: Thank you.

We'll go to the ranker on Health, Mr. Byrne.

ASSEMBLYMAN BYRNE: Thank you. I'm
going to try to be very watchful of that
clock, because we have a shrinking amount of
time. And I'm going to follow up on some of
the questions that I had before.

The opioid tax that was implemented
last session, where is that money going? And
is it going to folks who are suffering from
addiction?

COMMISSIONER ZUCKER: Does it go back
to helping those -- it's not --

ASSEMBLYMAN BYRNE: Dedicated funding,
I think I kind of -- it's not dedicated to
anything individual, correct?

COMMISSIONER ZUCKER: I don't think
it's specifically dedicated. But it's going
to tackle this whole issue in multiple
different sectors.

ASSEMBLYMAN BYRNE: I know -- speaking
for myself, and I think many of my
colleagues, I'd like to make sure that those
dollars are being used to help those who are
suffering from addiction.

Second question, with -- my colleague
 spoke about the 3 percent surcharge. Are
those dollars dedicated, or is that just
going to be sucked up into the Albany vacuum?

COMMISSIONER ZUCKER: Which, sir?

ASSEMBLYMAN BYRNE: The 3 percent
surcharge on, I'm sorry, the Certificate of
Need facilities that we were talking about
earlier when we started this hearing, several
hours back.

COMMISSIONER ZUCKER: Well, that's --
we were mentioning that it's administrative
and this has become very challenging, the
number of Certificate of Needs that are out
there. And if you're asking where it's going
to go, it's going to go to help making the
system even more efficient and more timely.

ASSEMBLYMAN BYRNE: So -- okay, so not
a specific dedication there.

Now, with -- I mentioned it before, a
bill that the Governor vetoed, Assembly Bill
7246, that removed prior authorization for
MAT in Medicaid. He vetoed that, but he
signed a different bill that wasn't specific
to Medicaid. It just seems I'm getting --
we're getting two kind of different messages
here. And this might be something to be
brought up with OASAS at a different public
hearing.

But it just seems to me that if we're
going to have revenue from the opioid tax,
that might be a place for revenue to go, to
help support those services, if it's
something that the administration wants to
make a priority.

So I just wanted to -- if you have a
response on the veto, that would be helpful.
But also I just wanted to plant that seed as
one of many options, I think, to try to help
expand that need.

COMMISSIONER ZUCKER: Well, the one
thing I will say about that is that we wanted
to look at that closer on the Medicaid front,
you know. And there are other components to
that that we're going to try to address
regarding the MAT from the Medicaid side.

ASSEMBLYMAN BYRNE: Now, before I run
out of time I want to follow up on a question
that my colleague Mr. Garbarino asked about
tobacco shops, an exemption for specialty
shops, like a cigar shop, tobacco shops.

You answered it specifically talking
about the marketing with flavors, but the
question was really about the language in the
budget from the Executive's proposal about
marketing in storefronts, signs, things like
that. It's not necessarily about flavors of
tobacco products.

So are tobacco shops, specialty shops,
are they going to be exempt from some of
those new requirements so they'll be able to
be still market within their stores? I mean,
it's pretty clear what they are, they're a
tobacco shop, and there's no other reason to
go there.

COMMISSIONER ZUCKER: So the -- it
will restrict the delivery of the e-liquid
products to New York State to -- only to
New York State-licensed vaping shops.
ASSEMBLYMAN BYRNE: That's the vape issue.

COMMISSIONER ZUCKER: Right.

ASSEMBLYMAN BYRNE: But there's other marketing about -- I thought there was inclusion of greater restrictions on the marketing of tobacco products as well, not just flavors. Signage in storefronts, things like that.

COMMISSIONER ZUCKER: Right. So, I mean, the issue will restrict all vaping-related ads targeted to youth. And you're asking whether that will be --

ASSEMBLYMAN BYRNE: And not just vape, but tobacco too.

COMMISSIONER ZUCKER: Of course, yes.

ASSEMBLYMAN BYRNE: Traditional tobacco.

COMMISSIONER ZUCKER: We've made a strong effort on the issues of tobacco. We've been very successful on that front in driving tobacco numbers down in the State of New York.

CHAIRWOMAN WEINSTEIN: Thank you.
And I believe the final questioner will be Assemblyman Ra.

ASSEMBLYMAN RA: Thank you, Commissioner. I just have a few issues I want to get into. Obviously my colleagues have covered a lot.

Just quickly, one that -- there was talk last year about coverage of applied behavior analysis for children with autism, through Medicaid. I know there's been a bill that's been around the Legislature for many years. Is there any status on possibly covering that administratively?

MEDICAID DIRECTOR FRESCATORE: The implementation of that coverage is underway. I don't have an effective date for you, but it is underway.

ASSEMBLYMAN RA: Okay. Thank you. I wanted to get into minimum wage as it relates to Medicaid. The numbers in the financial plan are, you know, higher, somewhat significantly higher than what was identified in last year's financial plan.

For financial year 2020 and 2021 we
have 1.5 billion, which is for 2020, which is
up from about 1.131 in last year's financial
plan, and 1.8 billion in 2021, which was, I
think, a little over 1.2 in last year's
financial plan.

So I'm just wondering, how are these
numbers being calculated? Are they just
wages? Do they include benefits? Do they
take into account, you know, the increases in
minimum wage potentially driving up -- you
know, higher wages?

MEDICAID DIRECTOR FRESCATORE: I think
they take into account all of those things.
So they have taken into account the change in
increase in minimum wage, which has now
reached $15 in New York City but continues to
escalate in other parts of the state.

And a large part of the increase that
you see from year to year is as the number of
hours of care increase. So as we see the
increase in use of long-term-care services
and enrollment in managed long term care
increase, the minimum wage costs increase as
well as more hours of care are provided.
ASSEMBLYMAN RA: And this data is coming from providers to the department, is that's how it's being calculated?

MEDICAID DIRECTOR FRESCATORE: I'm sorry, could you say that again?

ASSEMBLYMAN RA: How is this data -- who's providing the numbers to make these calculations?

MEDICAID DIRECTOR FRESCATORE: So for individuals who receive their care through fee-for-service, we actually have the claim data projected forward.

Because the fee-for-service system pays the claims, the data for the use of services for individuals in managed-care plans comes from managed-care reports and encounter data that show the number of services. Again, we're projecting forward based on expected enrollment trends, which are about 13 percent enrollment in managed long term care year to year.

ASSEMBLYMAN RA: Okay. And is the state reimbursing those providers for all the minimum-wage-related costs or just the share
attributed for the Medicaid recipients?

MEDICAID DIRECTOR FRESCATORE: The -- it's -- the Medicaid reimbursement is for -- it's built into the hourly rate that Medicaid reimburses for service rendered to a Medicaid-covered patient.

ASSEMBLYMAN RA: Thank you.

CHAIRWOMAN KRUEGER: Thank you. We've actually -- we haven't run out of questions for you, but we've run out of time to allow ourselves to ask more questions.

I think you have quite a long list of answers you're going to get back to us on.

So four hours, not that bad. Thank you -- depending on how you count. Thank you very much for being with us today.

And our next testifier will be Linda Lacewell, superintendent, New York State Department of Financial Services.

And a little leg stretching.

(Brief recess.)

CHAIRWOMAN KRUEGER: If people are exiting, can you take your conversations out of the room if you're exiting. Thank you.
And if you're staying -- look at you, all quieted down perfectly. Thank you.

Superintendent, are you ready?

SUPERINTENDENT LACEWELL: I am. Thank you, Senator.

CHAIRWOMAN KRUEGER: Thank you.

SUPERINTENDENT LACEWELL: Good afternoon to the chairs, to Chairs Weinstein, Krueger, Rivera, Gottfried, Breslin and Cahill, and to the ranking members and to all members, distinguished members, of the State Senate and Assembly.

Thank you for inviting me to testify today. I am Linda Lacewell. I am the Superintendent of Financial Services at the New York State Department of Financial Services. We regulate many things, but as relevant here, we regulate commercial health insurance for the State of New York.

I am privileged to work for Governor Cuomo and to have been confirmed by the State Senate -- thank you -- in this task to serve all New Yorkers in this role. I am happy to provide an overview or highlight some of the
primary relevant healthcare reforms at issue
with respect to the Governor's Executive
Budget. And I will of course do my utmost to
answer your questions here today and take
back anything where you would like additional
information.

The mission of DFS is to protect
New York State consumers of financial
products and services, to oversee the safety
and soundness of our banking and insurance
industries and financial service industries,
and to safeguard the markets from fraud and
illegal activity and maintain their
integrity.

We regulate more than 1400 insurers of
all kinds, with assets of more than
$4.7 trillion and nearly 1500 additional
banking and other financial institutions with
assets of more than $2.6 trillion. So it's
an awesome responsibility. We do at DFS play
a significant role in the health insurance
market, and we carry out many of the
Governor's initiatives to protect and improve
the healthcare for all New Yorkers.
This year's budget builds on many of the accomplishments from last year of the Legislature and the Governor in the budget, including of course the codification of vital protections of the Affordable Care Act and the Mental Health Parity Act and other such matters.

A few of the reforms proposed in this year's budget, as you know, include the matter of prescription drugs. The Governor is committed to fighting the high cost of prescription drugs. The budget he has proposed has a three-part plan; one, to cap the cost of insulin for consumers with respect to their out-of-pocket payments; two, to give DFS the ability to oversee pricing of prescription drugs where those prices spike; and three, to facilitate with DOH a feasibility study regarding the potential importation of drugs from Canada.

On the issue of pharmacy benefit managers, as you well know -- obviously this is a recurring issue -- they are intermediaries in the drug supply chain that
have amassed tremendous power and influence
with respect to the sale of federal
pharmaceuticals and the pricing, which of
course is a tremendous cost-driver with
respect to healthcare. Despite playing an
important role in highly regulated markets,
they have managed to be exempt from
regulation, and we have a resulting black box
with respect to their practices.

This year the Governor is proposing
legislation to bring PBMs under DFS
regulatory authority, to generate
transparency and light with respect to these
practices, to come up with a Code of Conduct,
and protect consumers from deceptive, unfair,
and abusive business practices.

With respect to surprise medical
bills, building on the prior work of the
Legislature and the Governor as we have led
the nation in protecting patients from
surprise medical bills, the Governor's budget
proposal would build on this success by
closing remaining loopholes that end up
passing on the cost to consumers, who should
be held harmless when there's a dispute
between the provider and the insurer;
requiring disclosure of fees that consumers
need to be aware of; and reducing the statute
of limitations on medical debt from six to
three years, which would bring us more in
line with a number of other states.

Additionally, the proposal would
provide medical cost transparency for
consumers of the pricing and quality of
medical services on a website that we would
work on in coordination with other agencies,
to bring that information in a
consumer-friendly manner to them.

As you know, the budget proposal
includes the vital issue of lifting the ban
on gestational surrogacy, which is important
to many people, and would create a
Surrogate's Bill of Rights to protect the
rights of the surrogate in that situation,
would ensure the right of the surrogate to
make her own healthcare decisions and have
access to comprehensive health insurance and
potentially life insurance.
Additionally, we have done vital work together on expanding fertility services. And as you know, the Governor's signed legislation expanding IVF coverage for large-group insurance plans and fertility preservation services, irrespective of plan, to millions of New Yorkers. We need to build on that work and continue the work and expand that realm.

On the issue of mental health parity compliance, DFS and other agencies have noted, as have many of you, that we have a lot of work to do on mental health parity and compliance, that the policies and procedures in place currently are not adequate, and therefore DFS, with DOH and other agencies, will drill down on that and issue regulations providing compliance, procedures and policies that must be followed, to help ensure that parity is a reality.

The financial services law passed in 2011 which created the Department of Financial Services is a piece of legislation designed to unify the oversight of banking,
insurance, and all financial products. It is vitally important that we have comprehensive standards to protect all consumers of all products, whether it's a banking product, an insurance product, or simply a financial product that doesn't fall into any of these categories. That was the intention of DFS being created post-financial crisis.

Therefore, an important proposal the Governor has put forward is a robust consumer protection agenda that, among other things, would bring much-needed oversight of the debt collection industry; expand financial inclusion and literacy across the state for all communities, so all can participate in the great financial products and services of this state and not limit it just to some; to reform the law to allow DFS to prevent and stop and generate relief with respect to abusive and deceptive practices, not just those that are intentional.

And this is important because unfortunately we lag behind many other states and even the federal government with respect
to the legal standard imposed on us to get
relief for consumers.

    I'm approaching my one-year
anniversary of beginning to work at DFS,
prior to, of course, my confirmation by the
Senate. I've been traveling the state, I've
been meeting with many of you, and also doing
some town halls to learn the concerns of your
constituents and our great New York
population. And one of the concerns that
keep me up at night -- and time after time,
what is brought to our attention -- are
practices that involve deception and unfair
practices that part New Yorkers from the
little money that many of them have as
they're balancing all the kitchen table
expenses that they have.

    Homeowners in Brooklyn and Harlem who
are potentially going into foreclosure, and
they think they're getting relief, and
instead they are tricked into signing away
the deed to their home. Teachers on
Long Island paying thousands of dollars more
than they should for fees for their
retirement plan while a large insurer across
the board is reaping profits. A young
graduate in Buffalo paying more than they
should on student loans and then dealing with
those who promise relief and instead drive
them further into debt. Families in the
Bronx and elsewhere who are entitled to file
their tax return for free, under the law, and
instead are tricked into paying the fee that
they really don't have in order to comply
with the obligation to file the tax return.
And our military forces, including at Fort
Drum, who are preyed on by subprime predatory
auto lenders.

Additionally, there is a barrage of
new untested and unregulated financial
products like never before. Consumer debt is
at record levels. Student loan debt is at
record levels. Student debt is second only
to mortgages in terms of debt; it's above
credit card debt, it's above auto debt, and
the default rates are above them as well.
This is not only a problem for consumers,
it's a drag on the economy.
Most troubling -- perhaps we should not be surprised -- many of these predatory practices target disproportionately our most vulnerable communities, which underscores the need for us to act. In that regard, as I close, let me quote from an op-ed that I was honored to coauthor with Assemblyman Tremaine Wright. "This agenda is more than just a consumer protection agenda. It is an economic and racial justice agenda that focuses on alleviating historical disparities and injustices that for too many years have resulted in communities of color being denied access to our financial system, targeted by predatory lenders, and victimized by perpetrators of deed and mortgage fraud, and holding a disproportionate share of student loan debt."

Thank you, Chair. I'd be happy to take your questions.

CHAIRWOMAN KRUEGER: Thank you.

We're still waiting for Neil Breslin, our chair of Insurance. So I'm going to jump to -- actually, Gustavo, chair of Health, did
you have any questions? All right, then I'm
jumping to Senator Seward.

SENERATOR SEWARD: Very good. I'm
flattered I'm the third choice here.

(Laughter.)

SENERATOR SEWARD: Madam Superintendent,
it's good to see you again.

SUPERINTENDENT LACEWELL: Good to see
you, sir.

SENERATOR SEWARD: And thank you for
your service in this new role.

I had a couple of questions
regarding -- in the prescription drug area.
There's language in the budget authorizing
investigations by the department with respect
to prescription drugs. And, you know, as I
read it, two events must occur concurrently
to trigger an investigation: An increase in
the price of the drug of 100 percent, and
suspicions of fraud.

Could you elaborate on that,
suspicion of fraud? I mean, what are we
really talking about here in terms of what
type of activities would trigger that?
SUPERINTENDENT LACEWELL: Thank you.

It's a pleasure to see you, Senator, and I have enjoyed getting to know you a little bit in this new role. So thank you.

Yes, you are correct, it is a two-part test, call it what you will. But at least the doubling of the drug within a one-year period and indicia of fraud. The idea there is the mere doubling of the drug price is not enough by itself, because there may be perfectly legitimate business reasons as to why that occurred. And one could look to all of those business-related reasons to determine whether, you know, in context with the rest of the industry, this is simply something that's occurring for industry or business-related or other innocuous purposes.

Or if there's some other indication that something is wrong. I view it as a guardrail around -- you don't jump into every spike on a drug price. I'm a former federal prosecutor, so I'm familiar with the indicia of fraud. But I view that as a guardrail around this potential new authority.
SENATOR SEWARD: Thank you.

How does this initiative in terms of giving your department investigation authority here, how does that relate to the Attorney General's investigative powers? I mean, is this overlap and duplication of resources?

SUPERINTENDENT LACEWELL: I've been pleased to work with our great Attorney General even in the short time that I've been at DFS, and we work very well together. I don't believe that this in any way impinges on her authority. And of course we would work together with her where there would be any potential overlap.

SENATOR SEWARD: One final question in this area, prescription drugs. I know in the Governor's State of the State message he mentioned looking at importing drugs from Canada at a less expensive rate -- and also the insulin cap.

SUPERINTENDENT LACEWELL: Yes.

SENATOR SEWARD: Now, as I read the budget, I don't find those in -- anything
related to those two in his budget proposal.
Would we be seeing something in the 30-day amendments? Or where are we heading on those two issues?

SUPERINTENDENT LACEWELL: Well, it may be that there's an understanding that DFS by regulation can cap the copays on insulin. And it may also be with respect to the Canadian drug importation that it's more a matter that the agencies have to work together, talk with the Canadians, talk with the federal authorities. But I will ask the Budget Division to get back to you on that.

SENATOR SEWARD: Okay, thank you.

Shifting over to PBMs, I know the Governor vetoed a bill -- of course I did not support the legislation when it passed the Senate, because I saw some problems there and agreed with the Governor, actually, on this issue. But one of those was -- one of the reasons for his veto was that the disclosure requirements could jeopardize trade secrets and conflicts with federal law that were included in that legislation.
And under the proposal that's in the budget, I note that disclosures to health plans do not receive the same level of confidentiality protections as the disclosures required -- that go to the superintendent. Is there a -- do you see a discrepancy there or -- shouldn't we be having confidentiality across the board in terms of those trade secrets and conflicts with federal law?

SUPERINTENDENT LACEWELL: Thank you for that, Senator. I'll take that back. My understanding, the primary issues with the prior bill were concerns about ERISA preemption and this fiduciary standard. But you make a good point on that third point, so we'll take that back.

SENATOR SEWARD: Okay, thank you. We look for some clarification there later.

Just one final question. Can you explain in a little more detail the code of conduct provisions? And do you have any concerns about increased costs, such as the federal analysis of the fiduciary duties and
responsibilities? Would this code of conduct trigger any increased costs associated with the federal analysis?

SUPERINTENDENT LACEWELL: Well, I think it is vitally important as a regulator to balance the need to bring about consumer protection and other kinds of protections in markets and to consider what the cost is on the other side. So we would be very mindful of that.

The idea of the code of conduct is a set of rules of the road that help to prevent any kind of inappropriate practices that are clear and transparent to the industry so that they know what the rules are ahead of time and they have that certainty. And I am mindful of the need in issuing any regulations, proposed regulations, to ensure that balance. Right? We need industry, we need businesses, we need jobs -- economic development is actually part of the purview of DFS in the statute. We also want to make sure that we protect consumers to the fullest extent possible.
CHAIRWOMAN KRUEGER: Thank --

SENATOR SEWARD: If I may, are you

going to, through regulation, develop the
code of conduct?

SUPERINTENDENT LACEWELL: I believe

that's right, under the bill. It's either
DFS or DFS and DOH together; I can't remember

as I sit here. But yes.

SENATOR SEWARD: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Assembly?

CHAIRWOMAN WEINSTEIN: To our

Insurance chair, Assemblyman Cahill.

ASSEMBLYMAN CAHILL: There we go, now

it's on.

Thanks for coming today. Hope this

meeting doesn't end as abruptly as our last

one did.

I see that the Governor is offering a

few new initiatives and a couple of

warmed-over proposals in his budget plan.

Our time here is limited, and there's a lot

to cover. I have about six areas that I want
to discuss. I'm not sure we're going to get
to them all.

So the first topic, or one of the topics, is your -- is the annual request from your department for powers currently reserved to the Attorney General. I know my colleague from the Senate just asked you about that; I know my colleague who's the ranker on our committee has some questions about that.

Revisiting of surprise bills and independent dispute resolution, behavioral health parity, pharmacy benefit management, excess medical malpractice insurance and the potential impact of a state-sponsored individual insurance mandate.

I'd like to start with PBM and just note that the Governor vetoed the Gottfried-Breslin plan for PBM, and he cited ERISA concerns and a few of the other matters that you just raised. What was the role of DFS, and your role in particular, at arriving at the veto message and in crafting the proposal that is before us today?

SUPERINTENDENT LACIEWELL: Well, obviously as a member of the cabinet, DFS
confers with the Governor's office, through
counsel's office and policy staff, with
respect to all proposals that intersect with
DFS. And every agency advises the Governor's
office with respect to bills that are sent to
him for consideration.

ASSEMBLYMAN CAHILL: So you had a
role, then, in --

ASSEMBLYMAN GOTTFRIED: Excuse me.
Could you pull the microphone closer?

SUPERINTENDENT LACEWELL: Me?

ASSEMBLYMAN GOTTFRIED: Yes.

Thank you.

ASSEMBLYMAN CAHILL: So then you had a
role in the crafting of the veto message and
also in the crafting of the proposal before
us. That's important to know.

SUPERINTENDENT LACEWELL: Well,
Assemblyman, I would not say that I had a
role in drafting it, nor would I get into
conversations between DFS and the Governor.
I'm saying that we always consult. That
doesn't mean that I drafted or had a role in
drafting.
ASSEMBLYMAN CAHILL: Oh. So can you
explain a little bit more what your
consulting role was in this process?
specifically with regard to PBM.

SUPERINTENDENT LACEWELL: Our role,
like any agency, is to advise the Governor's
office, counsel, the policy staff with
respect to matters in the experience of our
staff, on all matters that intersect with our
jurisdiction and authority. And that's what
we did. I -- many of those conversations, as
you know, Assemblyman, are privileged and
confidential, involving counsel, and I could
no more get into those deliberations than you
would want to get into your conversations
with the Senate.

ASSEMBLYMAN CAHILL: Well, I asked the
questions, with all due respect,
Superintendent, to frame the rest of my
questions to you to make sure that you
have -- that I'm asking you things for which
you have knowledge, as opposed to asking you
things that you'll be surmising or offering
an opinion on.
So we'll move to the next question on that front. Do you believe and does the Governor believe that PBMs should not have a legally binding duty of care to consumers and providers? I note that that's a difference between the Gottfried/Breslin proposal and the various proposals that have been offered by the Governor's office.

SUPERINTENDENT LACEWELL: You spoke a little too fast for me in the beginning. Do I believe what?

ASSEMBLYMAN CAHILL: Do you believe and does the Governor believe that PBMs should not have a legally binding duty of care to consumers and providers?

SUPERINTENDENT LACEWELL: Oh, I see.

To my understanding, there was a concern that putting in a fiduciary duty with respect to consumers could have the effect of generating legal problems, and therefore we would have no relief for consumers through the bill.

So do I believe that all actors that interact with consumers have obligations with
respect to consumers? I do. Can I
categorize that as a fiduciary duty in all
instances, depending on the panoply of
relationships that that entity has? I really
can't get that far.

ASSEMBLYMAN CAHILL: Well, I'll let
Assemblyman Gottfried re-explain his bill to
you. But there was nothing in there that
required a fiduciary obligation.

Were the Governor's proposals arrived
at with input from the industry and any
particular PBM? And in advance of that, did
you -- or at any point did you or anyone in
your agency have contact with any PBM or
their representative in developing your PBM
proposal?

SUPERINTENDENT LACEWELL: Well, you
have -- are you talking about this year or
last year?

ASSEMBLYMAN CAHILL: I'll talk about
any time you want.

SUPERINTENDENT LACEWELL: Well,
because remember, I came into office in
February of last year.
ASSEMBLYMAN CAHILL: Right.

SUPERINTENDENT LACEWELL: In the middle of the budget process. So my information --

ASSEMBLYMAN CAHILL: Okay, so since you've been here.

SUPERINTENDENT LACEWELL: -- is pretty limited.

ASSEMBLYMAN CAHILL: So the answer to the question is did -- the question remains, did you or anyone in your agency have any contact or communications with anyone in the PBM industry or any individual PBM in the crafting of this proposal or anything about the regulation of pharmacy benefit management companies?

SUPERINTENDENT LACEWELL: When you say "this proposal," which proposal do you mean?

ASSEMBLYMAN CAHILL: This proposal is the one you're here to talk about today, the one that's in the budget.

SUPERINTENDENT LACEWELL: The one pending here now.

ASSEMBLYMAN CAHILL: Yes. And also,
by the way, as long as we're on the subject,
in the crafting of the veto message having to
do with the Breslin/Gottfried bill.

SUPERINTENDENT LACEWELL: Well, thank
you for that clarification, because that's
very helpful to me, because as I indicated, I
really just came into DFS in February of last
year, and that was a mid-budget process. So
I don't have any information -- I certainly
was not involved in the drafting of the veto
message. Leaving aside, of course, that the
agency, as I indicated, does advise the
Governor's office, like every other agency
does, with respect to bills that come across
the Governor's desk.

I don't have information about whether
any PBMs were individually consulted.
Obviously, there are only three of them.

I can, of course, say -- which I think
you are aware -- that CVS Caremark committed
that they would not oppose a PBM bill when
DFS was reviewing the merger. That of course
is before I came into DFS. That was under
the prior superintendent.
ASSEMBLYMAN CAHILL: But my question is to you, have you had any contact with CVS Caremark or any other PBM with regard to this subject since that time?

SUPERINTENDENT LACEWELL: I have not.

ASSEMBLYMAN CAHILL: You have not.

Anybody in your office?

SUPERINTENDENT LACEWELL: I can get back to you on that. I don't know as I sit here.

ASSEMBLYMAN CAHILL: That would be great if you could.

What is the budgetary impact of the Governor's proposal to regulate pharmacy benefit managers?

SUPERINTENDENT LACEWELL: The budgetary impact would be none, because --

ASSEMBLYMAN CAHILL: None.

SUPERINTENDENT LACEWELL: -- any costs would come through assessments. Which, as you know, is how DFS is staffed.

ASSEMBLYMAN CAHILL: Okay, so -- so there is not a budgetary relationship to this PBM proposal, then, if I'm understanding your
answer correctly.

I just want to be clear whether this is appropriate to be an Article VII in the budget -- or maybe it should be handled through separate legislation, as we've proposed in the past.

SUPERINTENDENT LACEWELL: Well, I don't know as I sit here if the Budget Division is expecting any savings, given that pharmaceutical prices are a driver. But I -- all of DFS is typically handled through the budget, even though we are assessment-driven. So I think it's entirely consistent with the way that DFS is handled in the budget in all years.

ASSEMBLYMAN CAHILL: But even though you're assessment-driven, aren't the assessments also included as part of the overall state budget? Isn't it something that would or would not be reflected in a budget plan that's being advanced to the Legislature? And is anything advanced to the Legislature in that regard insofar as PBMs are concerned?
SUPERINTENDENT LACEWELL: Yeah, that's a good point. Thank you.

ASSEMBLYMAN CAHILL: Well, what's the answer? I don't care about the point.

SUPERINTENDENT LACEWELL: Oh. I thought you were making a point rhetorically. But yes, of course, you're correct.

ASSEMBLYMAN CAHILL: No, that's other people. I ask actual questions and hope we get some actual answers once in a while.

SUPERINTENDENT LACEWELL: I do my best.

ASSEMBLYMAN CAHILL: I'll move on to -- just curious if this year are you aware if there's any industry support or if once again Caremark has indicated that they will not oppose the Governor's proposal. Is that still the case this year, as it was last year?

SUPERINTENDENT LACEWELL: Yes.

ASSEMBLYMAN CAHILL: Okay. And last year, as you might know -- because although you were not in office that long, when the PBM association came in to testify, they did
express some concerns about it. So let's
hope that they have figured out that circular
firing squad this year.

    Let's move on to the question that I
don't know whether it is specifically lined
out in the budget. It was hinted at by a few
different folks associated with the budget.
And this has to do with the individual
mandate.

    Is it a real idea being considered to
have a state individual mandate? And if so,
how much would it add or save to the budget?

    SUPERINTENDENT LACEWELL: I -- I think
that that question is probably not within my
purview and is more of DOH. I don't have
information for you on that.

    ASSEMBLYMAN CAHILL: Because an
individual mandate is whether someone is
required to get insurance or not. So I
thought maybe the commissioner -- the
superintendent who is in charge of insurance
would be able -- that's fine.

    Let's talk about excess medical
malpractice. The program -- your regulatory
authority is being extended through June of 2021 under the Governor's proposal. The funding for excess medical malpractice will expire on June 30th of this year. How is it proposed that the excess medical malpractice insurance continue to remain affordable for our hospitals that are on the ropes and our providers, those specific providers who qualify under the program?

SUPERINTENDENT LACEWELL: Well, I expect that will be a matter of discussion through the budget negotiations between the Legislature and the Executive.

ASSEMBLYMAN CAHILL: So there is no plan right now to make sure that it's affordable after what the Governor put into the budget that expires on June 30th?

SUPERINTENDENT LACEWELL: I don't have information for you on that.

ASSEMBLYMAN CAHILL: Behavioral health parity. From a regulator's point of view, what exactly is the problem? And are you using, to the fullest extent possible, the existing tools that you have to enforce the
federal mandate?

SUPERINTENDENT LACEWELL: Well, we were pleased that the mental health parity bill was included last year and is in law, and we've been doing a lot of work on that. There have been a lot of complaints about network adequacy and the ability of individuals to actually access mental health and addiction-related services. And this is vitally important, and it is complex. It's not just a matter of DFS, it's OASAS, it's OMH, it's DOH.

And so to my understanding, the thought is that all those agencies should get together and provide clear direction and guidance to the industry as to what the compliance standards are for meeting that parity. And we intend to act robustly in that regard.

CHAIRWOMAN KRUEGER: Thank you.

ASSEMBLYMAN CAHILL: Thank you, Madam Chair. I'll come back for my next five.

CHAIRWOMAN KRUEGER: Thank you. We've been joined by Senator Carlucci and
Senator Sanders and by the chair of our Insurance Committee, Senator Breslin, who is up next for questions.

SENATOR BRESLIN: Good afternoon, Superintendent Lacewell, and I apologize that I had other commitments to get to before I was able to get here. And if I duplicate any questions, please feel free to correct me.

SUPERINTENDENT LACEWELL: Thank you, sir.

SENATOR BRESLIN: I appreciate the several conversations we've had, so you already understand some of the things that I do disagree with, which I would consider numerous, but much of which came before you became the superintendent. I would hope -- as I've told you, I felt that the veto of the formulary bill, the veto of the PBM bill was very, very anti-consumer, ill-advised, and came out with a bad result that affects the entire industry and does not protect the consumer. Other than that, I liked it.

(Laughter.)

SENATOR BRESLIN: So is the -- one of
the problems that I've had with the
Department of Financial Services up until you
were appointed is that they're their own
people, they don't include the Legislature in
discussions, they feel as though they're
preemptive in the field, and we come up with
plans like the Prescription Drug Pricing and
Accountability Board, which has been touted
in descriptions of the upcoming budget, but I
think is more prosecutorially oriented than
dealing with things like the PBMs.

And I think that we will see a lot of
closings of independent pharmacy in the
coming year. And I would hope that during
the following six weeks that we can have
discussions between and among obviously the
chairman from the Assembly, myself, the
health people, to discuss the two principal
bills, PBM and the formulary bill.

And I assume that most of the
provocative questions, knowing Senator Seward
and Assemblyman -- the chairman of the
Assembly Insurance Committee, they've already
been asked. But I think that there's
probably a sense with this panel that there's
so much more that one of the most important
offices, DFS, can do in the area of pharmacy
benefits, pharmacy benefit managers,
formulary plans, and just the whole plethora
of issues that to me are very difficult for
the general public to understand, and it
places a greater burden on the financial
services and on the Legislature --
particularly the Legislature -- to do its due
diligence, perform in a way that makes it a
better, better world dealing with
pharmaceuticals and pricing and ethics within
the pharmacy benefit managers.

And unless there is total
accountability, I just don't want to see a
pharmacy benefit manager plan than gives the
name, rank and serial number. I want to make
sure that every possible element of their
ability to abuse is discussed properly
between and among the Legislature and the
DFS, to come up with the best possible piece
of legislation.

And I would hope that some of these
items aren't crammed down us in a budget that
obviously contains a lot more policy than the
people on this stage would like it to have,
and that we come up with a resolution in
these areas of something that's very
positive.

And I know that's more of a statement
than a question, but I'd appreciate your
response.

SUPERINTENDENT LACEWELL: Thank you,
Senator. I appreciate the statement.

I have expressed to you individually
and to a number of other members that I not
only recognize but I fully embrace the
importance of working together with you.
These are complex issues. You and other
members have deep experience on these issues
year after year.

The problems are complicated enough
that we're not going to arrive at the best
solutions unless we work it through together.
And I am committed to doing that, and that is
why I have been coming and having these
conversations.
And on a personal level, I appreciate that even where we may disagree or where you may be unhappy with the Executive or some conduct, that we continue to have a constructive professional working relationship. And that is vitally important, because there's so much work for us to do together.

So I am delighted to work with you, to work with others, whoever it's important to have around the table, to work through these, because I want to get it right too. At the end of the day, it's in my hands.

SENATOR BRESLIN: Thank you. And I'll limit my questions to that, assuming that the others have been asked, and I'll ask for a copy of the recording of participating and working together, and I'll share it with some of the other people in the Senate and send a copy to you.

SUPERINTENDENT LACEWELL: Thank you, sir.

SENATOR BRESLIN: Thank you.

CHAIRWOMAN KRUEGER: Thank you.
CHAIRWOMAN WEINSTEIN: To our Health chair, Assemblyman Gottfried.

ASSEMBLYMAN GOTTFRIED:
Superintendent, you're licensed to practice law, yes?

SUPERINTENDENT LACEWELL: Yes.

ASSEMBLYMAN GOTTFRIED: If you were in private practice and a client found that you were not providing legal services with care, skill, prudence, diligence and professionalism, you could get into real trouble for that, couldn't you?

SUPERINTENDENT LACEWELL: Yes.

ASSEMBLYMAN GOTTFRIED: Yeah. So would it be a problem to say that -- for the law to say of PBMs that they should provide their services with care, skill, prudence, diligence and professionalism?

SUPERINTENDENT LACEWELL: No, I think that's entirely appropriate.

ASSEMBLYMAN GOTTFRIED: And when we were discussing the fate of the PBM bill with the executive branch a month or so ago, one
of the demands was that those very words be taken out of the bill.

SUPERINTENDENT LACEWELL: Well, there may be a difference between a belief of how actors should operate and the legal consequence of using particular language in a bill when it lands in front of a judge.

I know that you're aware of these issues, and reasonable people can disagree on the impact. But especially for a new law or a new regulatory regime, legal risk is an important factor because otherwise, if a new protection is held up in the courts for a long period of time, then we've simply delayed arriving at the justice that all of you are trying to generate.

ASSEMBLYMAN GOTTFRIED: But these are words that, by common law, are a legal mandate on shoe repair people and carpenters and doctors and lawyers and real estate agents. Why wouldn't we want that to be a legal command on a PBM?

SUPERINTENDENT LACEWELL: Well, again, I would say we may want that to be a legal
command on them, but if there are court
opinions that raise questions about the legal
viability of the language in the bill, then
again I would say we are just self-defeating.
There's an ability to take a close look at
what the practices are and to generate
regulations and do this with full visibility
into what the practices are and hopefully
arrive at the same result.

ASSEMBLYMAN GOTTFRIED: So you think
if we had a bill to require carpenters to
exercise skill and care, et cetera, that the
carpenters might be able to sue to get that
overturned? I mean, that's really strange.

SUPERINTENDENT LACEWELL: Well, I'm
not trying to defend any legal opinions out
there that raise concerns about the viability
of such a standard. I'm simply saying that
if there are legal opinions out there that
raise concerns about the viability of the
standard, then all we do is delay achieving
the reform that the members and the Executive
appropriately want to achieve.

And so if we can do it in a cleaner
manner where the bill doesn't end up getting held up, even though it's signed into law, then that's all to the better, justice delayed is justice denied, and let's just get it done.

ASSEMBLYMAN GOTTFRIED: Are you familiar -- and I don't know that I have ever had the experience of citing favorably the work product of the current U.S. Justice Department. But are you familiar with the amicus brief filed by the Justice Department with the Supreme Court in support of the Arkansas PBM statute? Which is remarkably similar to the one that just got vetoed in New York.

SUPERINTENDENT LACEWELL: I'm happy to take a look at it. I haven't seen that particular brief.

I'm aware, obviously, that the issue is being litigated across the board, and I'm happy to take a look at that.

ASSEMBLYMAN GOTTFRIED: Okay. Because it is to me an astonishingly lucid and sensible document. Only the astonishment, of
course, is just because of the current administration in Washington.

But I think it makes perfectly clear that -- and coming from, you know, the current Washington administration's Justice Department, makes perfectly clear that the legislation, the PBM bill that got vetoed, is actually on -- would actually be on enormously solid ground.

So I would commend that to you.

SUPERINTENDENT LACEWELL: I'll take a look.

ASSEMBLYMAN GOTTFRIED: Okay, thank you.

SUPERINTENDENT LACEWELL: Thank you, sir.

CHAIRWOMAN KRUEGER: You're done with your --

ASSEMBLYMAN GOTTFRIED: I'm done.

Yes, I'm done.

CHAIRWOMAN KRUEGER: Only seconds to spare. Thank you.

Senator Savino for the next questions.

SENATOR SAVINO: Thank you,
Senator Krueger.

Good afternoon, Superintendent.

I'm going to ask you a question that I asked the Commissioner of Health, about the long-term-care program, because one of the largest driving forces in the increase in Medicaid spending is on long-term care. And so there's only a 30-day lookback period for long-term-care Medicaid services, where there's a five-year lookback for nursing homes. So I'm just wondering, is there any idea that maybe we should change that and line them up?

Or also, what are we doing to incentivize insurers to provide lower-cost long-term-care insurance? I hear from many of my constituents who had the wisdom to buy it that the premiums have gone up significantly in the past couple of years, and they've been approved every time by the Department of Financial Services. And it's putting them in a position where they're now considering dropping the long-term-care insurance just at the point in their life
when they really probably will need it.

So what can we do to bring these
products into the marketplace in a fairer way
so that people who need them can purchase
them?

SUPERINTENDENT LACEWELL: Thank you,
Senator. Long term care insurance, as you
know, is a national problem, it's a national
crisis. New York is in a little better
position than many other states because the
oversight tends to be more robust in New York
State.

I've had conversations with other
members, including Senator Krueger, about
this problem.

I think that -- well, first of all,
with respect to the rates, I don't believe
that DFS has simply approved the rate
proposals. We have approved increases, but
not at the level that's been requested. And
unfortunately, we have an obligation in that
regard to ensure the solvency of the insurer
in question. So we have to strike that
balance of approving only as much, you know,
as can be justified with an eye toward the solvency.

And obviously I am painfully aware that it is the consumer, it's the insured who is left with the impact on this. Obviously the product was underpriced many years ago. Everyone here is deeply familiar with what the problems are -- rising cost of insurance, the low interest rates, the lapse rates being less than expected.

I think you're also probably aware that one of the things offered to consumers who have had these policies for many years is an ability to sort of reshape the benefits, known as landing spots. Which is not ideal either, but at least it keeps the policy in force.

There's no question that we have got to focus on this problem, both with respect to the old policies and making sure that new policies, appropriately priced, are available for consumers. And I think that there are some creative ideas emerging about different ways of offering this kind of product in the
marketplace. I don't think any of them are ready for prime time.

We're having conversations with the Department of Health; be happy to work with you and the Department of Health and anyone else who's interested, to drill down on these.

SENATOR SAVINO: I would appreciate that.

And finally, even though it's not the subject of this -- as you know, the medical marijuana program has been in existence five years now. And when it opened, it was somewhat the Wild West out there with respect to insurance coverage. Now we know it doesn't pay for, insurance will not pay for the product. But many physicians out there that are providers are making up the rules as they go along.

Your predecessor was kind enough to prepare an article to send out to doctors to tell them that they cannot charge patients for the patient visits, and they seem to be ignoring it. So they're charging -- they're
just making it up -- $500 for a visit, $500 to prepare the application for being approved by a patient.

So I would hope that you will work with me to come up with some way to send that message out there that while insurance doesn't pay for the medical marijuana, you're not supposed to charge patients cash for visits when they have an insurance policy.

SUPERINTENDENT LACEWELL: Absolutely, we'll work with you on that, Senator. Thank you.

SENATOR SAVINO: Thank you.

CHAIRWOMAN KRUEGER: Okay, Assembly.

CHAIRWOMAN WEINSTEIN: We go to Assemblyman Jacobson.

ASSEMBLYMAN JACOBSON: Thank you, Madam Chair.

I want to view another area that your department has, and that's concerning the review of denial of prescriptions and medical procedures. The process is called an external appeal. I mean, what happens is if somebody gets denied, they go through their
insurance company, their internal process,
then they have the external appeal. At best,
your process is incomplete, because what
happens is you outsource the decision-making.
And in the case that my constituent had, it
was outsourced to an outfit called IMEDICS.
They gave the facts to three different IMEs.
Two came back affirming the denial, one came
back saying it should have been approved.
And this was a situation for hydrogel.
The patient was involved in prostate cancer
treatment, and this protects you.
So the problem is -- so we wrote
letters and said that someone's got to review
it, because the credibility of the two
reports that denied it was terrible. I mean,
you had it -- they were relying on outdated
reports, they referred to the prescription of
the medication as experimental, yet it was --
has been approved by the FDA.
So -- and I know from my experience as
a workers' comp judge and practicing workers'
comp law for many years, IMEs, independent
medical exams, they're not like God speaking.
I mean, they go there, they do their work, they're overwhelmed.

So I wrote a letter attacking the credibility. And everybody was very polite in your office -- I mean, they were all polite and got back to us. And then the decision was, Well, we have no power. So what is it? You outsource it, they come back with faulty IMEs that the decision has relied on, and then you don't review it.

So my question is is that you -- are you saying you don't have the power to do that?

SUPERINTENDENT LACEWELL:  So, Assemblyman, thank you for bringing that to our attention. And obviously we had a chance to speak for a few moments earlier today, and I know our staff has been working with your staff.

It is very important that we do everything we can to improve the accuracy of the basis of the decisions that are reached in any of these administrative proceedings and that we have appropriate safeguards in
place and sufficient due process so that
-going to court is a last resort, because I
know that's outside the reach of many.

So we are going to take a close look
at our processes are and what our authorities
are and what other agencies do and what other
systems do, and see what we can do to bring
about greater reliability in that process.

ASSEMBLYMAN JACOBSON: I will be
introducing legislation. But the problem
here is that nobody there is reviewing your
outsource decision. So the decision comes
back, and it's there, so you say, Okay, it
still is going to be denied because that's
what two out of three IMEs said.

But the IMEs that were writing were
clueless. They were using outdated reports
that were contradicted by another report that
the one IME that approved it cited. And like
I mentioned, they said it was experimental.

And so what there has to be is
something -- I can't believe I'm going to say
these next words -- similar to workers'
compensation, which has its own problems, but
at least there is a semblance of a fair procedure when you go from the trial level to a review panel to the full review by the commissioners.

SUPERINTENDENT LACEWELL: Thank you, Assemblyman. And as I indicated, we're going to work with you on that, and we'll see what we can do to bring about a better process.

ASSEMBLYMAN JACOBSON: All right, thank you.

CHAIRWOMAN WEINSTEIN: Senate? Oh, I'm sorry, before we go to the Senate I just wanted to acknowledge that Assemblyman Félix Ortiz joined us a little while ago.

CHAIRWOMAN KRUEGER: Great. And we're rejoined by Senators Jackson, I think I said Sanders already. And Senator Gallivan is up next.

SENATOR GALLIVAN: Thank you. Good afternoon. I want to touch on two areas. Both the Governor mentioned, but I don't believe that they actually appeared in this proposed budget.

The first had to do with the
importation of prescription drugs from
Canada. Do you know what the proposal is,
and will it be included in the 30-day
amendments?

SUPERINTENDENT LACEWELL: So the
proposal, as I understand it, is to consider
going through a process of speaking with
authorities in Canada and speaking with
relevant federal authorities to see whether
there is a viable proposal to put forward for
approval to allow the importation.

Some localities have done this,
apparently. And so I think the Governor was
putting this forward and being transparent
that this is something that we would be
seeking to do.

So to my understanding, that's why you
would not have seen particular language on
it, but it's wrapped together with his other
initiatives to do something about the high
cost of prescription drugs.

SENATOR GALLIVAN: Do you know if
we'll see it in the amendments?

SUPERINTENDENT LACEWELL: I will ask
the Division of Budget to get back to you on
that. That question did come up a little
earlier, and I did commit to do that.

SENATOR GALLIVAN: The other -- same
general area -- he mentioned a cap on
insulin, on the price of insulin or copays.
Do you know what the specific proposal is, or
will we see it?

SUPERINTENDENT LACEWELL: To my
understanding, the concept is that DFS would
issue regulations in that regard, or other
legal authority to industry to cap that, and
that we have the authority to do so.

So again, I think the Governor was
being transparent about the range of items
that would be sought to address the high cost
of prescription drugs.

SENATOR GALLIVAN: Okay, thanks.

Going back to PBMs and the proposal
related to that, in particular, it calls for
an assessment on the PBMs to cover increased
costs, administrative costs for DFS. Do you
have any concern that this -- or how do we
know that this will not actually raise the
cost of prescription drugs for the consumer?

SUPERINTENDENT LACEWELL: Well, thank you for the question. Of course it's the last thing we want to do. But as I'm sure you are aware, the way that DFS is funded is through assessment on industry and not through taxpayer dollars.

And so where we have additional work to do, we have to have people to do the work, and that cost is borne by the industry that's being regulated.

Typically those costs would not be so large as to do something so impactful as to affect prices. And additionally, alongside, obviously, the idea is that these various measures together are a way of helping stabilize or bring down drug prices.

SENATOR GALLIVAN: I suppose it's really too early without seeing specifics or seeing numbers, but I think that's a concern to be aware of.

SUPERINTENDENT LACEWELL: All right, thank you.

SENATOR GALLIVAN: Thank you. Thank
you, Madam Chair.

CHAIRWOMAN KRUEGER: Thank you.
Assembly.

CHAIRWOMAN WEINSTEIN: So we've been joined by Assemblywoman Hunter, and we go to Assemblyman Garbarino for questions.

ASSEMBLYMAN GARBARINO: Thank you, Chairwoman.

I just want to follow up again, I know Chairman Cahill asked you about the medical malpractice extender. Now, I don't understand, it's dropping about 22 million from last year to this year's budget appropriation. Why is that?

SUPERINTENDENT LACEWELL: I'll have to get back to you on that. I'm just not familiar with the -- with those numbers.

ASSEMBLYMAN GARBARINO: Okay. Why isn't it being extended? I know he tried to ask, and I didn't really hear the answer.

SUPERINTENDENT LACEWELL: I think what he was saying is that DFS authority is being extended, but is the money being extended in parallel.
ASSEMBLYMAN GARBARINO: Okay. So but it's -- from my reading, it doesn't extend past June, though, correct, the authority to purchase?

SUPERINTENDENT LACEWELL: Correct.

ASSEMBLYMAN GARBARINO: Why not?

SUPERINTENDENT LACEWELL: I think the idea is that these are all matters under discussion, and this would be a matter, I think, to be discussed between the Legislature and the Executive. Although I am happy to go back and see if I can get answers to some of these questions to make it a little easier for you.

ASSEMBLYMAN GARBARINO: Now, is this -- I've heard rumors, but I don't know if it's true. Is this something that they're hoping to discuss under MRT II?

SUPERINTENDENT LACEWELL: Yes, I think that the MRT -- the concept is the MRT is opening to considering issues affecting medical malpractice.

ASSEMBLYMAN GARBARINO: Okay, so is somebody from DFS going to be on MRT II?
SUPERINTENDENT LACEWELL: I'm not aware at this time.

ASSEMBLYMAN GARBARINO: Because I looked at the last MRT, and nobody from the Department of Insurance or -- I think DFS was created afterwards -- nobody was on MRT I.

So if we're going to be discussing medical malpractice insurance and other things at MRT II, I would hope maybe someone from your department, if not you --

SUPERINTENDENT LACEWELL: Well, and if not, certainly we would confer as appropriate and as needed.

ASSEMBLYMAN GARBARINO: You regulate and approve increases in health plan insurance premiums, correct? If they're requesting an increase, you have to approve it?

SUPERINTENDENT LACEWELL: Yes.

ASSEMBLYMAN GARBARINO: Now, MRT II, there's a -- in discussions they have to raise $2.5 billion by April 1st. If there's a -- do you think it's appropriate for them to discuss possible increases in taxes on
health plans?

SUPERINTENDENT LACEWELL: Well, the MRT of course is Medicaid-cost-related and we regulate commercial health insurance plans. So I think that that's really more a matter for Medicaid and the Department of Health and the Division of the Budget.

ASSEMBLYMAN GARBARINO: But if Medicaid decides -- I know you regulate commercial health, but if Medicaid {sic} decides to raise taxes on these commercial plans, they have to then, to make up that cost, they might have to ask for premium increases, which reflects back to you.

SUPERINTENDENT LACEWELL: Oh, I see. I misunderstood your question. To my understanding, I believe the Budget Director was asked if such taxes were contemplated, and he didn't rule it out. So I -- we would defer to allow the process to unfold. Obviously, there will be many conversations to sort through a lot of these issues, and I would not want to be disruptive of that process by presupposing that that's
on the table.

ASSEMBLYMAN GARBARINO: Okay. But again, if MRT II discusses possible increases in taxes to these health plans, do you think it would be appropriate to have someone from DFS on MRT II?

SUPERINTENDENT LACEWELL: Certainly we would like to be a part of the dialogue. I don't know if membership is needed. But certainly I would expect that anything affecting commercial health insurers, that DFS would be consulted. And I have no reason to believe that that would not happen.

ASSEMBLYMAN GARBARINO: Okay, thank you.

CHAIRWOMAN WEINSTEIN: Senate?

CHAIRWOMAN KRUEGER: Thank you. Hi. We've gotten to me. So the Governor's budget proposal includes portions of a bill some of us carried in both houses, the Patient Medical Debt Protection Act, but not Part G of our bill, which would hold consumers harmless from plan or provider misinformation.
Can you explain why the Governor didn't include Part G from our bill?

SUPERINTENDENT LACEWELL: I unfortunately cannot shed light on why that would not be included. Obviously changing the statute of limitations, if that's what you're referring to in the first part, is vitally important to reduce that to something reasonable for consumers. I am of course generally in favor of more consumer protection across the board. And I'm happy to confer with the chamber -- obviously, you have the ability and I'm sure you are yourself, but I'm happy to talk to them.

CHAIRWOMAN KRUEGER: But I would love if you could take a look at the original bill, take a look at the Governor's proposal, and if you agree Part G is important, urge him, as a representative of his administration, to add Part G in his 30-day amendments. Because I think we actually would all agree on the whole package.

SUPERINTENDENT LACEWELL: Okay. Thank you.
CHAIRWOMAN KRUEGER: Okay? Thank you.

He also talked about, in his State of the State, but then I didn't find it anywhere in the budget, which requires disclosure of the facility fees in medical billing. Which seems to me is probably your territory also.

Can you explain to me why he talked about it -- and I agree with him -- but then I couldn't find it anywhere in the budget? Is it something you just do through regulation, it doesn't need to be in the budget?

SUPERINTENDENT LACEWELL: I believe that that's the understanding, and I'm going to confirm that. I believe DFS could do that through regulation. And again, that's the Governor being transparent about his intention in that regard. But I will get back to you on that.

CHAIRWOMAN KRUEGER: Thank you.

Appreciate that as well.

So people have asked about insulin and the PBMs. So there's still a debate in both houses around the concepts of surrogacy and
legality of surrogacy, and I have my own bill, but I don't think it should be part of the budget. But if the Governor's proposal for surrogacy were to become the law, there's a set of requirements for insurance coverage for surrogates --

SUPERINTENDENT LACEWELL: Yes. Yes.

CHAIRWOMAN KRUEGER: -- and for actually, in my version, for egg donors as well, who put themselves at risk being egg donors.

Do we have any law that would require insurance policies for -- in a surrogate situation because it's not a, quote, unquote, traditional family model or specifically for egg donors, or are you going to need to come up with new regulations, slash, law separate than I think anything we've seen yet to ensure that we have the correct insurance coverage existing in New York?

SUPERINTENDENT LACEWELL: So to my understanding, the provision in the Governor's Executive Budget with respect to health insurance -- and by the way, potentially life
insurance for the surrogate -- is simply articulating and providing the right of the surrogate to have this insurance and have it paid for by the intended parents.

With respect to the coverage itself, there would be nothing unusual about that type of insurance policy. And the role of DFS, as I see it, would be to issue guidance to industry to insure that they understand that and that they are making available the existing policies they have without discrimination because of the fact that it happens to be in the context of surrogacy.

CHAIRWOMAN KRUEGER: Okay. There are some other people who seem to believe it's a bigger problem than that, so I will have them follow up with you.

SUPERINTENDENT LACEWELL: All right.

CHAIRWOMAN KRUEGER: But again, for my purposes, there's still great debate about many of the pieces of surrogacy, and we shouldn't be rushed through the budget.

Ah. The program that we refer to as the Medical Indemnity Fund, which was DFS's
from the beginning up until, sometime this
year, some pieces of it got transferred to
DOH. But I think you're the right one to
ask.

The budget does not include annual
funding from HCRA continuing to go into the
fund. When we created this, which was for
babies who were born damaged but instead of
the families going through the medical
malpractice court process, we were creating a
insurance fund guaranteeing that adequate
healthcare would be provided for their babies
till -- for as long in their life as they
needed the supplemental healthcare.

And I believe that HCRA was scheduled
to contribute 51 or $52 million this year,
but in the Governor's budget we're skipping
that.

One -- a couple of questions and
follow-up. One, this program was never
designed so that the taxpayer picked up the
cost. It was the hospitals agreeing to pick
up the cost so that they did not have to deal
with these cases one by one in medical
malpractice cases through the court, one.

Two, it's not at all clear that
there's an adequate funding stream into the
outyears, considering 70 to 80 children are
being added per year.

And three, we had provided an enhanced
provider rate when we learned there were very
few providers who were willing to take on
these children at the lower Medicaid rates,
and that's also sunsetting. So are we going
to make sure we have the adequate provider
enhanced rate continuing? We've got money
coming in through HCRA to make sure this fund
is not running dry.

And again, I'm not exactly sure what
part of it went to DOH, but I see you as the
correct agency to be asking the questions of.

SUPERINTENDENT LACEWELL: Thank you,

Senator.

Well, the budget last year formally
transferred the program to DOH effective
October 1st of last year, and that transfer
is complete. So I will need to get with DOH
and the Division of the Budget and ensure
that we get you the answers to these questions and that your concerns are appropriately conveyed.

CHAIRWOMAN KRUEGER: So your agency had done a study on the projected long-term costs of this program at the growth rate it was going at. So did those functions also then move over to DOH, or are they supposed to keep asking you those kinds of questions?

Because again, it's an indemnity fund, like other insurance. And I don't know that DOH is in the business of knowing how to evaluate -- I mean, not a criticism of them, I just think DFS is who evaluates whether there is, you know, adequate resources and insurance.

SUPERINTENDENT LACEWELL: Right.

CHAIRWOMAN KRUEGER: And DOH doesn't.

So I'm concerned that whatever reason it moved to DOH, they're not the ones to actually stay on top of this over time.

SUPERINTENDENT LACEWELL: All right, I understand what you're saying. We'll come back to you.
ASSEMBLYMAN ABINANTI: Hello, Superintendent. Nice to see you again.

SUPERINTENDENT LACEWELL: The same.

ASSEMBLYMAN ABINANTI: We had a chance to chat the other day, and -- but I guess we're in a more formal environment now.

I'd like to take a look at the big picture first. As I understand, your budget is pretty much flat, but you have a $1.3 million increase in your budget. Is that correct?

SUPERINTENDENT LACEWELL: Additional FTEs, perhaps.

ASSEMBLYMAN ABINANTI: Correct, okay. Now, how much of the additional cost is attributable to the expansion of enforcements that you're looking at that you've proposed here in the health field? And I notice in the banking area there's four Article VII
proposals, all of which will expand your functioning and your responsibilities.

Is that why you're going to have the $1.3 million increase?

SUPERINTENDENT LACEWELL: Well, I don't have the ability to break it down right now. But certainly as we take on additional responsibilities, that requires additional personnel and that generally results in assessments to the industry, and that gets captured in the overall budget.

But I'm happy to confer internally and have appropriate staff sit with your staff to walk you through it.

ASSEMBLYMAN ABINANTI: Yeah, I would like to do that. Because you are saying to this panel of legislators that you're going to be able to do all of the things that you promise in here, and that you have the staff to do that. And I'm frankly concerned about giving power to an office that doesn't have the capacity to handle the new work.

SUPERINTENDENT LACEWELL: Understood.

ASSEMBLYMAN ABINANTI: And -- for
example, do you have -- how many lawyers do you have on staff? How many litigators do you have a staff?

SUPERINTENDENT LACEWELL: Well, that's a tough question, because in addition to our general counsel, we have lawyers who are seeded through -- S-E-E-D-E-D, seeded through -- the other bureaus and divisions. And we have about 1335 individuals across the board. We have many examiners, many lawyers.

ASSEMBLYMAN ABINANTI: Right. But you're asking for additional power in general.

SUPERINTENDENT LACEWELL: Yes.

ASSEMBLYMAN ABINANTI: We can deal with that separately from the Banking Committee. But even here today, you're talking about subpoena power, you're talking about hearings, you're talking about all kinds of things that I'm assuming you're going to need lawyers for.

SUPERINTENDENT LACEWELL: Yes. And of course --

ASSEMBLYMAN ABINANTI: So I'm kind of
probing here to see, you know, what resources
you have to do this stuff you're talking
about.

SUPERINTENDENT LACEWELL: Right.

Well, I think that we issue subpoenas now, we
do hearings now, and a whole range of things,
and this would be an additional subject
matter that many of those same lawyers would
be engaged in those activities.

But then, in addition, the concept is
if you're regulating a new segment of
industry, you'll need some additional
personnel in that regard.

ASSEMBLYMAN ABINANTI: Right. But
isn't the Attorney General's office doing
some of the things that you want to take over
doing?

SUPERINTENDENT LACEWELL: No, I don't
believe that's correct, sir.

ASSEMBLYMAN ABINANTI: Well, we're
talking here about, for example, the
increased authority with respect to
prescription drugs. And you want to issue
subpoenas, refer investigations, hold
hearings.

That was a state law that you're talking about enforcing, right?

SUPERINTENDENT LACEWELL: Well --

ASSEMBLYMAN ABINANTI: Wouldn't the Attorney General's office be doing that otherwise?

SUPERINTENDENT LACEWELL: There are multiple -- as you know, Assemblyman, there are multiple authorities across the state that can conduct investigations and issue subpoenas and engage in enforcement. And simply because something is a matter of investigation and enforcement doesn't diminish the ability of another authority to look at a question if that's within their purview and is a priority of theirs.

And as I indicated earlier, we have a very good relationship with our great Attorney General. And by the way, she's our lawyer, right, she represents us in litigation. We have a great relationship. We've brought matters together with her, and I'm not anticipating --
ASSEMBLYMAN ABINANTI: Let me jump to another area. I want to follow up on the Senator's question about the MIF. Now, it was transferred from you to the Health Department.

SUPERINTENDENT LACEWELL: Yes.

ASSEMBLYMAN ABINANTI: Did you transfer the funding and the personnel that were operating that, or do they remain on your staff?

SUPERINTENDENT LACEWELL: Well, I don't know that there were personnel that were dedicated to the MIF that would be transferred over. But I'm going to drill down on that, which I already need to do, given the prior question, and I'll --

ASSEMBLYMAN ABINANTI: The Behavioral Health Parity Compliance Fund, which is in your comments, is that going to be new monies coming in?

SUPERINTENDENT LACEWELL: Yes. The concept is that if there are penalties that come in due to violations of these --

ASSEMBLYMAN ABINANTI: Will those be
going into the General Fund or a separate fund outside the budget?

SUPERINTENDENT LACEWELL: I believe that the proposal is that those would go into a particular fund to be used --

ASSEMBLYMAN ABINANTI: But outside the General Fund, outside the budget, to finance enforcement? Or are we talking about money that's just going to be coming into the General Fund and you're going to do the enforcement with your present staff?

SUPERINTENDENT LACEWELL: As proposed, the money would go into a fund that would be dedicated to the matter that is being regulated in that regard. Not into the General Fund.

ASSEMBLYMAN ABINANTI: Can you give us an estimate of how much money you expect to come in?

SUPERINTENDENT LACEWELL: I couldn't begin to estimate.

ASSEMBLYMAN ABINANTI: Could you give it to us later?

SUPERINTENDENT LACEWELL: I will look
at it and come back to you, certainly.

ASSEMBLYMAN ABINANTI: Thank you.

SUPERINTENDENT LACEWELL: Thank you, sir.

CHAIRWOMAN WEINSTEIN: Thank you.

We go to Assemblyman Byrne.

ASSEMBLYMAN BYRNE: Thank you. And thank you, Superintendent, for being here and being so patient, sitting there and answering our questions.

Just looking at some of your testimony regarding the high cost of prescription drugs are the largest driver of premium rates — and we know there's many factors. Obviously, the cost of medicine is one of them. I would suggest maybe mandated benefits could increase costs as well as taxes. So that was kind of one of my questions to start with.

The health plans released a report indicating New York taxed health insurers $5.2 billion last year through the covered lives assessment, the HCRA surcharge premium tax. And my understanding is the HCRA tax is actually the third largest state tax behind
only the personal income tax and sales tax.

    And if we're concerned about
increasing premiums and the cost of insurance
for consumers, would the administration at
least be -- would they be willing to consider
a moratorium, holding a line on those taxes?
Because as was mentioned earlier with MRT II,
there is some concern about dipping into
things as revenue raisers, and ultimately
that could increase the cost of premiums for
consumers. So is that something that you
would be able to do?

    SUPERINTENDENT LACEWELL: Well, thank
you, Assemblyman. So obviously healthcare
products and services are a large part of the
economy, generate a lot of jobs, a lot of
economic activity and, as you indicate,
generate fees and a tax base to help provide
the infrastructure for these benefits going
to individuals downstream.

    The idea of the prescription drug
regulation or regulatory package is that the
prices of the prescription drugs may in some
instances be unchecked, and that it is
important enough, because it is such a cost
driver, that we need to understand the
reasons, we need to have guardrails around
it, we need to set out what the practices
should be, we need to understand what the
pricing models are, what's effective, where
the costs are being imposed. And --

ASSEMBLYMAN BYRNE: I'm sorry, not to
interrupt, I just -- I am looking at that
clock.

But -- and I understand that, it kind
of goes into one of my other questions about
the DAB that you've been speaking about
already with regards to prescription drugs.
But would the administration commit to not
raising HCRA taxes or assessments on
healthcare bills as a means to closing the
Medicaid spending gap? That's one of the
things I'm concerned about. Are we going to
start dipping into increasing taxes, which
could increase premiums for people paying for
private health insurance right now?

SUPERINTENDENT LACEWELL: Right. So I
understand that you would obviously raise
that in your discussions with the Executive.
I am at DFS, and I am not in charge of taxes.

ASSEMBLYMAN BYRNE: Okay. Now, going
back to what you were speaking about a little
bit before with this creation of this new
Drug Accountability Board within the budget
proposal that's been mentioned already. And
you've kind of answered this a little bit,
but could you just elaborate a little bit
more? What are we doing right now? What
roles and responsibilities do we have right
now to help address this issue? And is this
a duplication of efforts?

I know you mentioned that you have a
relationship, obviously, with the Attorney
General's office and that there are multiple
agencies that have similar authorities and
powers. But is it necessary to create a
whole new board to accomplish the goal here,
or do we already have tools and laws in place
today that you could take advantage of to get
to -- to address the needs that we're trying
to address right here?

SUPERINTENDENT LACEWELL: Thank you,
Assemblyman.

I think the idea of the board is to bring the experts together who are deeply involved in understanding the pharmaceutical industry, and in healthcare, so that you've got the experts around the table who are in a position to advise with respect to what may be driving the cost spiking in prescription drugs. I think it's similar to the Medicaid Drug Utilization Review Board, which is a similar concept where experts get together and they're in a position to advise on the appropriateness of the pricing of the drug.

ASSEMBLYMAN BYRNE: So could you just explain again the difference between the Attorney General's office powers and what you would be looking for through DAB, as far as if you found a company to be doing something nefarious and you think they're price gouging, if they're committing a crime, and the Attorney General's office has powers to act on that. So what would -- what's the difference?

SUPERINTENDENT LACEWELL: By the way,
the Attorney General does not have
independent authority on the criminal side.
She would need a referral from a relevant
agency, and perhaps that would be us.

In other words, we can investigate and
we have the ability to refer it to her, under
the Executive Law, to provide her with
criminal authority if a crime may be
occurring.

ASSEMBLYMAN BYRNE: Okay, thank you.
I'm out of time.

CHAIRWOMAN WEINSTEIN: Thank you.

We go to Senator Little.

SENATOR LITTLE: Thank you,
Superintendent, for being here. You
certainly have a number of things in your
purview in your agency.

SUPERINTENDENT LACEWELL: Yes.

SENATOR LITTLE: But the one big
concern I have is the PBMs. And a lot of
questions have been asked about it, so I'm
not going to continue in that vein. But I
just want to stress how important it is that
something be done, because we are losing
independent pharmacies. It does affect the
chain pharmacies just as much, but they have
a bigger base to work with, and they're in
multiple states and not so -- you know, they
can cover each other. Whereas an independent
pharmacy has no way of staying alive.

We just lost one that had been in
existence for I think almost 75 years, and
they closed their doors in January, this past
month, so.

The problem -- and the Governor has
this listed, all the things that they want
you to do: To begin to license them, to
begin to have some oversight, to work on how
they're collecting. They raise the prices on
their drugs that the pharmacist has to pay,
and yet the insurance doesn't pay. They are
losing money by filling some prescriptions.
And, you know, no business can continue that
way.

And they definitely believe that there
is a conflict of interest here between some
of the PBMs and the health plans in
existence.
So I would just ask you to seriously look into this. It says by 2022. Something needs to be done faster than that, because we're going to lose more and more.

You know, I have -- two of my biggest areas are Glens Falls and Queensbury, a population probably about 48,000, of my district. Not one independent pharmacy left. So I would just like to say that and stress the importance of that.

SUPERINTENDENT LACEWELL: All right, thank you, Senator. I will take that to heart.

SENATOR LITTLE: Thank you.

ASSEMBLYMAN CAHILL: All done, Betty?

Thank you. Then we will move to Assemblyman Félix Ortiz.

ASSEMBLYMAN ORTIZ: Thank you, Mr. Chairman, thank you very much.

Thank you, Superintendent, and good afternoon.

SUPERINTENDENT LACEWELL: Good afternoon.

ASSEMBLYMAN ORTIZ: I do have a very
quick question. What does the state require
as a minimum standard for services in the
insurance plan?

SUPERINTENDENT LACEWELL: The minimum
standard?

ASSEMBLYMAN ORTIZ: Yes, ma'am.
SUPERINTENDENT LACEWELL: For
insurance?

ASSEMBLYMAN ORTIZ: Yes.
SUPERINTENDENT LACEWELL: I don't know
if I know exactly what you mean. But
obviously there a number of requirements
before one can be licensed to engage in the
business of insurance.

ASSEMBLYMAN ORTIZ: Just to clarify,
it's about the insurance company -- you know,
what is the minimum that they can offer if I
buy insurance for my family? Health
insurance.

SUPERINTENDENT LACEWELL: For health
insurance.

ASSEMBLYMAN ORTIZ: Yes, ma'am.
SUPERINTENDENT LACEWELL: Well, there
is a set of essential benefits that are in
law, and that's part of what we codified last year with the Affordable Care Act, as to what commercial health insurers have to include. And I'm happy to come back and provide your staff with that detailed list, or if there's a more specific question you have in that regard.

ASSEMBLYMAN ORTIZ: Let me just ask you a few other questions regarding that. The DFS, and I quote, according to your testimony right here, the DFS, quote, regulates more than 1400 insurance with assets of more than $4.7 trillion, and I'm going to close quotes there.

And I also see here that the Governor is trying to do a wonderful thing about the Mental Health Parity and Equity Act compliances. I'm going to give you this quick scenario, because I do have time, a quick scenario.

I do have constituents in my district who suffer from eating disorders. An eating disorder is a very difficult -- and we can call it a mental health disease or illness to
treat. One of the things that I find out through my constituents is that when they go through the treatments, health insurance regularly do not cover enough for the coverage.

One, what do the -- what your agency can do to make sure that we be able to assist these individuals who are -- have to pay out of their pocket $5,000, $10,000 a month for treatment.

Secondly, I find out that sometimes the kids that suffer or the adults that suffer from -- or the teenager that suffers from an eating disorder, sometimes they need one or two or three psychologists. And because of the qualifications that they use, they are already removed from the insurance company to pay for those services. If you go to a psychiatrist, also the same thing happens.

So I'm bringing this to your attention because I know that the Governor in his wonderful State of the State and this paper that I see here in my hands has a lot of
initiatives for increased coverage for
different areas. And I will be asking for a
big please on behalf of this community, that
if you do have the authority to look into it
these insurance companies and work with the
other entities or agencies who have the
authority as well, that we do what is right
for my people or my kids in my district
that's -- I'm asking the State of New York
because I was the guy who did the three
eating disorder centers, and the money's
gone, which is a shame, and they had to close
down and we don't have a real outpatient
clinic, in-service patient clinic in the
State of New York to take care of our kids.

And the parent has to spend their own
money, they have to sell their homes, their
stores, their businesses, whatever savings
they have, in order to take care of their
children. And I am a testimony of that with
my granddaughter.

So I ask you and I plead you to please
let's make these insurance companies
accountable, let's not make the insurance
company to continue to treat and make
decisions on behalf of our children, our
families, and to choose the treatment that
they need to get, because they want to be
part of the treatment of this disorder.

Thank you for hearing me and hearing
the people of my community. Thank you.

SUPERINTENDENT LACEWELL: Thank you.
And thank you for those remarks and for
sharing that story.

Obviously, eating disorders are part
of the larger issue of mental health, and
insurers are supposed to provide parity on
mental health and physical health in terms of
what they cover, and their networks are
supposed to be just as robust, and their
practices are supposed to be equivalent.

I believe that mental health is the
last frontier with respect to a major area of
health insurance that needs to be addressed.
Unfortunately, many people still view mental
health issues as bringing stigma, and people
are reluctant to step forward. When they
step forward, we should make sure that they
get the help that they need. And we should
make sure that if they're not willing to
speak up, that we're speaking up for them.

The mental health parity compliance
proposed regulations that are in the
Governor's proposal would go squarely to this
issue. And I've already had a number of deep
conversations with our staff about how we
address the problem of making sure that our
insurers comply with their responsibilities.

Just because you put a network
together and it's got three people in it but
they're not accepting new patients, that's
not adequate. I don't care what the
definition is of adequacy, it doesn't cut it,
as a regulator. And parity is real, and
mental health is just as vitally important as
physical health, and it's got to be treated
the same.

I think many of us have family and
close friends who have incurred issues.
Young people and others, eating disorders are
a very big problem. I think that there is a
significant date coming up for the advocates
in that field, and I believe there may be an 
opportunity for a broader dialogue between 
the Executive and the Legislature and the 
advocacy community and the industry on this 
point.

ASSEMBLYMAN ORTIZ: I do have 
legislation on it, and I like to share with 
you. Thank you.

CHAIRWOMAN WEINSTEIN: Thank you, 
Assemblyman Ortiz.

We've been joined by Assemblywoman 
Buttenschon and Assemblyman Steck.

And we now go to Assemblywoman Hunter 
for a question.

ASSEMBLYWOMAN HUNTER: Thank you. 
Superintendent, it's a pleasure to be 
here today. I actually have the privilege of 
being on the Insurance Committee and actually 
sitting on the Opioid Task Force for the 
Speaker, and so I bring questions to you from 
those angles.

I wanted to -- two things, two 
comments and then two questions.

One, wanted to voice with my
colleagues concerns relative to the veto
about the PBMs. I too have community
pharmacies in my district that it impacts.
And also wanted to voice my distress for the
veto for the continuing education bill. It
went around two times, and the first message
was relative to too many credits; the second
message was saying that this would set a
course for other, I guess, industries to
follow the same.

And I say that's great, especially
when these professional associations, you
have to spend many dollars in order to be a
part of them, and they're the perfect
effects and organizations to provide
professional conferences and curriculum.

But my two questions.

So we've been having many
conversations about prescription drug costs
and figuring about the pricing, how does the
pricing work. And I think that's a circular
question. I nationally have this
conversation about how drug costs come into
play, and I've basically had to go back to my
constituents and say they can increase it because they can. And that's literally the answer I was given from Pharma.

So as we're thinking about, you know, how we reduce costs and increase fees -- and, you know, I'm the last one -- and especially in the district that I represent that is diverse and has a high concentration of poverty, there are two areas which it doesn't seem have been addressed in the budget which I think could be important.

One, and I don't necessarily think people should be getting their health information necessarily from Good Morning America. But I do think that when you hear about a national recall, and we're talking about something like Ranitidine -- and I get questions about this from my constituents -- who pays either the consumer back for their insurance payment, the -- I guess the state back -- the plans back for the portion that they have paid, back to the manufacturer who is selling these drugs that are cancer-causing.
And I guess I would want to know the question to that, because it seems like we're spending a lot of money to find out that drugs have been recalled because there's been significant health risks, but people aren't getting their money back.

And my second question would be related to the opioid resettlement dollars. And I don't know how much money has been allocated to New York State, but I know that there's a huge lawsuit and money is supposed to be coming back, and wanting to know how we plan on addressing that coming into New York State. Obviously, you can't spend money you don't have. But it seems to me, with the high rate of deaths that we're having relative to opioid use, we need to be doing something different than we've been doing, because the rates are increasing, they're not decreasing.

So those two questions,

Ms. Superintendent. Thank you.

SUPERINTENDENT LACEWELL: And thank you, Assemblywoman.
With respect to the opioid lawsuits for New York, the lawsuit is being litigated by the Attorney General. And my understanding is negotiations, as has been publicly reported, you know, continued apace. And those are complex pieces of litigation with multiple states and localities involved in those.

For DFS, we initiated last fall, as we publicly stated, an investigation with respect on people who have commercial health insurance whose rates have been increased over time due to the overprescribing of opioids and the need for the addiction-related services, which generated a lot of cost for commercial insurers. And as you know, those get passed on to the individual policyholders through rate increases.

And so it isn't that the health insurers are out of money, because in a sense they've been reimbursed, it's as usual consumers who have been left holding the bag. And so what we have determined is
that, you know, in excess of a billion and
perhaps up to $2 billion over the past 10
years was passed on to New Yorkers in the
form of rate increases due to the opioid
crisis and that scandal and the
overprescribing and the need for the
addiction services.

And so we are -- we have a very
intensive investigation that is geared at
trying to get back some of that money for the
money for the benefit of the consumers.

Your question -- your first question I
think is sort of a related thought, which is
when there is some kind of wrongdoing or
scandal or inappropriateness, who then is
looking out for the consumer who is
out-of-pocket, and how do we get that money
back to that person?

And so we'll take a close look at that
on the question of recalls, because I'm less
familiar with how that works. But, you know,
I'm happy to work with you on that and think
that through. And if we can do something
about it appropriately, then we'll do so.
CHAIRWOMAN WEINSTEIN: Thank you.

We go to Assemblyman Salka.

ASSEMBLYMAN SALKA: Thank you, Madam Chairwoman.

And thank you, Superintendent. Thank you for the work that you do.

I've got a little problem with this 3 percent surcharge on Certificate of Needs, applications for Certificate of Needs.

From what I understand, the figure of around 70 million is going to be generated. An I correct in that? I heard that this morning. Do you -- are you familiar with that figure?

SUPERINTENDENT LACEWELL: I don't know the number, but that may be right.

ASSEMBLYMAN SALKA: Okay. I was just wondering, I mean -- well, some technical questions about how those surcharges are calculated. Is it the size of the project? Or am I asking the wrong person this question?

SUPERINTENDENT LACEWELL: Well, if I understand what you're saying, I don't know
that it's a question for DFS. I think this is DOH and Medicaid and the Division of the Budget. If I can be helpful in facilitating the conversation, I'm happy to do so.

ASSEMBLYMAN SALKA: Oh, good. Okay. All right. Yeah, basically, I want to know where the money is going to come from. You can't charge it against Medicaid, so obviously when you're applying for a Certificate of Need, the money's got to come from somewhere and it's going to have to be passed along to somebody. And it seems to me like it might just end up increasing costs that eventually trickle down to the patient.

SUPERINTENDENT LACEWELL: Yeah. Well, I think that Certificates of Need are within the purview of the Department of Health. But our staff will work with yours to make sure you get the information you need.

ASSEMBLYMAN SALKA: All right, thank you.

CHAIRWOMAN WEINSTEIN: Assemblyman Cahill.

ASSEMBLYMAN CAHILL: Thank you,
Madam Chair.

Superintendent, a couple of follow-up questions to things that we've discussed already. The first one is whether the Attorney General has registered in one way or the other on your proposal for the additional powers that you described as filling the gap where DFS lags far behind the federal government and other states.

SUPERINTENDENT LACEWELL: I have no reason to believe that she opposes that proposal. Obviously, you can speak with her. But I have received no information that she is concerned about that proposal. As I said, we have a very good working relationship.

And the view of those typically who enforce the law is that there's a lot of work out there to be done and we need multiple players to get the work done to protect New Yorkers.

ASSEMBLYMAN CAHILL: So that's half of the answer.

Did the Attorney General indicate that she supported your proposal?
SUPERINTENDENT LACEWELL: I have not spoken with the Attorney General about the proposal. I'm not familiar with her weighing in one way or the other.

ASSEMBLYMAN CAHILL: I want to go to the surprise billing modifications that the Governor is proposing in the budget and talk about the concept of provisional credentialing.

Can you please explain how provisional credentialing is supposed to work from a quality and systematic billing point of view, if somebody is provisionally credentialed?

SUPERINTENDENT LACEWELL: You'll have to give me more of a context. Provisional credentialing of what? I'm not familiar with that issue.

ASSEMBLYMAN CAHILL: Well, in the Governor's reform under surprise billing, he's indicated that they will require insurance companies to provisionally credential providers. My question is, how would that actually work mechanically?

SUPERINTENDENT LACEWELL: Oh, I see.
I'll have to get back to you on the mechanics of it.

ASSEMBLYMAN CAHILL: Okay, thanks.

Earlier I asked you about CVS Caremark's position with regard to the Governor's proposal on regulating PBM, and you indicated -- I asked you if they indicated support for the legislation, and you said they did.

I guess my question to you is, how did you become aware of that? Is that something that has been communicated to your office by CVS Caremark?

SUPERINTENDENT LACEWELL: Thank you for the question.

I believe that their agreement not to oppose regulation is in the public record, both through the press release from DFS approving the merger through Troy Oechsner's testimony last year in the Budget Committee, and otherwise reported in the press.

ASSEMBLYMAN CAHILL: So you're -- you're -- and I will ask you the question. Are you referring to that which was discussed
by DFS in October of 2018, which would have
been prior to your tenure, prior to the
Governor's veto, and prior to this current
proposal?

SUPERINTENDENT LACEWELL: Mr. Oechsner
tested before this committee within days
of me taking office at DFS, so he did the
budget testimony. I was at DFS at the time.
And I have reviewed his testimony, and I
watched the video recording where he
tested before this committee and read his
remarks, and there are also written remarks,
that CVS had agreed not to oppose regulation.

ASSEMBLYMAN CAHILL: So again, my
question is pertaining to the very proposal
before us right now in the 2020 budget
proposal by the Governor. And my question to
you was whether CVS indicated that they would
support or oppose this. Your answer to me
was that they were going to support it.

I'm now asking you specifically, have
they addressed the 2020 proposal -- not
Mr. Oechsner's testimony which was offered
last year before this proposal was made, not
in October of 2018 when CVS Caremark was
laying down the conditions for their
acquisition or the merger with Aetna
Insurance Company, but this very proposal?
Has there been any communication to
you or, to your knowledge, with the
Governor's office on this specific proposal
from CVS Caremark?
SUPERINTENDENT LACEWELL: I don't have
specific information about any such
conversations. I certainly haven't had those
conversations.
I am generally aware that over the
course of time, those who have been working
on proposals to be presented have indicated
that the larger PBMs understand that
regulation is coming and they're expecting
that, and that they're not standing in the
way of that.
What their position is on a particular
bill or a version of a bill, I couldn't say.
I would be very surprised indeed if CVS now
reversed its position and said "We're opposed
to being regulated," when in fact it was an
express condition of DFS approval of the
merger.

ASSEMBLYMAN CAHILL: All right. Thank
you very much.

CHAIRWOMAN WEINSTEIN: Thank you.

Superintendent, I have just one quick
question, really a follow-up to some of the
discussion that people have raised about the
Drug Accountability Board.

How will DFS ensure that there's no
conflict of interest between members of the
Drug Accountability Board, pharmaceutical
companies, while still ensuring that members
of the board will have sufficient expertise
to perform their duties?

SUPERINTENDENT LACEWELL: So that's a
good question. And that is the perennial
problem, of course, because you want
stakeholders from an industry as a whole, if
you're going to get the complete picture of
representation.

So I understand your point about
conflicts of interest, and I'll go back
through the bill which indicates what the
composition ought to be. And of course it includes the Department of Health, which is a very important component in terms of generating neutrality and integrity of those deliberations.

CHAIRWOMAN WEINSTEIN: Well, thank you for that response, and also for your being here today.

CHAIRWOMAN KRUEGER: Yes, thank you very much. I was just right there.

SUPERINTENDENT LACEWELL: Thank you.

CHAIRWOMAN WEINSTEIN: So I think that concludes the questions from both the Senate and the Assembly. Thank you.

SUPERINTENDENT LACEWELL: Thank you very much.

CHAIRWOMAN KRUEGER: Thank you. Appreciate it.

And for those following, we're still on page 1. And we have Dennis Rosen, Inspector General, the New York State Office of Medicaid Inspector General. And he's been here before with us. Actually, I saw him here all day. So if he wants to answer DOH
or DFS questions, maybe he'll be ready to do
that also.

INSPECTOR GENERAL ROSEN: Good
afternoon.

CHAIRWOMAN KRUEGER: Hi. Whenever
you're ready.

INSPECTOR GENERAL ROSEN: Okay. Good
afternoon, everyone. As you have my full
testimony before you, I will provide a brief
summary and be happy to answer any questions.

OMIG's comprehensive investigative and
auditing efforts, extensive partnerships with
law enforcement agencies and collaborative
work with agencies and stakeholders across
the state are projected to deliver more than
$2.8 billion in cost savings and Medicaid
recoveries in calendar year 2019.

Preliminary 2019 figures indicate the
agency's proactive cost avoidance measures,
which prevent, up front, inappropriate
Medicaid payments, generated estimated
savings of more than $2.3 billion. OMIG
recoveries, including audits, third-party
liability and investigations, total more than
$542 million.

In addition, OMIG had many successful collaborations with law enforcement. For example, OMIG played a key role in a 2019 joint investigation with the Attorney General's Medicaid Fraud Control Unit, New York State Department of Health, and United States Department of Health and Human Services Office of the Inspector General. It led to the arrests of a New York City pharmacy owner and three of her managers for their alleged participation in a $10 million Medicaid fraud scheme involving kickbacks and HIV prescription drug diversion.

The defendants filed thousands of false claims for reimbursement from Medicaid and Medicaid managed care organizations for refills that were not dispensed, an illegal practice known as auto refilling. The maximum state prison sentence for these offenses is 25 years.

Also in 2019 OMIG continued its vital work with its partners to address the opioid crisis. The agency's recipient restriction
program is a key tool in this effort. It helps prevent the filing of duplicate prescriptions through doctor or pharmacy shopping by restricting patients suspected of overuse or abuse to a single designated healthcare provider and pharmacy.

Preliminary 2019 data show 1,767 of the 1,992 Medicaid recipients reviewed were recommended for restriction to the appropriate Medicaid managed care plan, county agency, or New York State of Health. As a result, more than $85 million in costs to the Medicaid program were avoided, and quite likely many lives were saved.

The agency’s 2019 preliminary enforcement statistics show strong results. OMIG opened more than 2,800 investigations, completed over 2,700 investigations, and referred more than 800 cases to law enforcement and other federal, state and local agencies. Additionally, OMIG issued more than 700 Medicaid exclusions. Exclusions are a powerful program integrity tool, and an excluded provider is prohibited
from participating in New York's Medicaid
program and any other state's program.

OMIG continues to focus on and
implement new initiatives related to program
integrity within the managed care arena.
Efforts include performing various
match-based audits and utilizing data mining
and analyses to uncover trends or patterns
that identify future reviews. Audits result
in the recovery of inappropriate premium
payments and identify actions to address
systemic and/or programmatic issues.

Preliminary data for 2019 indicate these
efforts resulted in 483 finalized audits,
with more than $177 million in recoveries.

OMIG also continues to review managed
care plans' Provider Investigative Reports,
which started just a couple of years ago,
which plans are contractually obligated to
submit to OMIG and DOH quarterly. The report
provides valuable information, including
MCOs' provider investigative activities and
disclosures of any MCO settlement agreements
with network providers.
Through legislation enacted in 2019, OMIG acquired a very significant additional managed care program integrity tool. OMIG is authorized to conduct annual reviews of all MCOs and MLTCs to assess their compliance with contractual standards that prevent fraud, waste or abuse, such as jettisoning from their networks providers that have been excluded from the Medicaid program at the federal or state level, utilizing effective recipient restriction programs, complying with various reporting obligations, maintaining adequate compliance programs, and suspending provider payments when appropriate.

Implementing statewide this critical program integrity review initiative has been a major OMIG focus, and I'm proud to report on our progress today. Comprehensive reviews of each of New York's 15 mainstream MCOs are well underway. Year 2 of the effort will include, in addition to the mainstream plans, reviews of MLTCs.

Also last year, OMIG continued to
provide extensive provider outreach and education -- through educational webinars, guidance materials, presentations and on-site meetings -- to associations, provider groups and other stakeholders across the state.

OMIG's website has been enhanced to better serve the provider community and the public, and the agency maintains an email listserv with more than 5,100 subscribers.

Finally, OMIG currently posts 42 fee-for-service audit protocols on its website, which continue to apprise the healthcare industry of what OMIG looks for when we conduct an audit.

OMIG's comprehensive Medicaid program integrity efforts are a critical part of New York's healthcare delivery system. My office looks forward to playing an integral role in the MRT initiative and will continue to devote resources to strengthen program integrity and efficiency, thereby ensuring that the most vulnerable New York dollars -- I'm sorry, the most vulnerable New York taxpayers and recipients -- taxpayers save
their money, and recipients receive the
high-quality care that they deserve.

Sorry, I think sitting here may have
affected my ability to read this well for
you.

Thank you. I'd be pleased to address
any questions you may have.

CHAIRWOMAN KRUEGER: Thank you.

Senator Gustavo Rivera.

SENATOR RIVERA: Thank you, ma'am.

I know we've had some issues in the
past. Can you hear me all right?

CHAIRWOMAN KRUEGER: Yes.

INSPECTOR GENERAL ROSEN: Yes.

SENATOR RIVERA: Just say -- can you
hear me?

INSPECTOR GENERAL ROSEN: Yes.

SENATOR RIVERA: Very well.

INSPECTOR GENERAL ROSEN: I can hear
you. Just please speak up, because sometimes
I had had issues.

SENATOR RIVERA: Yes. This is why I
want to make sure that -- it will be just one
question. It relates to the role and the
scope of the work that OMIG does, in
reference to some of the concerns that the
proposal in front of us, to try to fix
Medicaid, seems to want to address. And
particularly when you're talking about
determining eligibility -- the counties'
responsibility in determining eligibility for
Medicaid patients.

There is a proposal that obviously
doesn't cover your office, right, there is a
proposal -- are you familiar with the
proposal that is currently being considered?

INSPECTOR GENERAL ROSEN: We really
have no role to play with the initial
determinations as to eligibility. And so
we're not particularly familiar with the --
that side of program.

SENATOR RIVERA: So you don't have an
auditing or overseeing responsibility as
relates to counties and their -- in their
determination of eligibility?

INSPECTOR GENERAL ROSEN: Not with
respect to the initial determination. We
work very well with the counties on other
levels post-determination.

We have a recipient fraud program where we cooperatively work with the counties to root out recipient fraud; very often those may result in referrals to law enforcement. We do secondary audits. Once somebody is in the programs, we do audits to see, for example, that in managed care the person is in the program, they haven't left the state, they haven't passed away, issues like that. And in fact those audits have resulted in -- last year have resulted in about $54 million.

But the initial determination of eligibility is a DOH and a county issue.

SENATOR RIVERA: Okay. So you don't have -- you not having any role in looking into that -- because there seems -- and you might not be able to answer this question, but there have been the -- what we have heard from either the Governor or the Medicaid Director or the Department of Health related to counties' actions or not. They suggest that some counties are doing something wrong, and when that's brought up and the question
is asked specifically "So you're saying that
counties are doing something wrong?" "Oh,
no, no, no, we're not saying that, but"
and it just seems to go into this circle.

And so I just was trying to understand
the role of OMIG as it relates to what the
counties do originally as far the
determination of eligibility, which is what
the proposal seems to want to address, you
have nothing to do with that?

INSPECTOR GENERAL ROSEN: Yeah. And
in fact, again, I think in many areas we've
worked very well with the counties,
particularly the expanding transportation
area. And I would like to take this
opportunity, frankly, to put the word out
that we'd ask counties to consider enrolling
in our county demo project, demonstration
program.

There is opportunity there for
counties to make recoveries with our
collaboration. They can keep some of the
money that's recovered. And I know in the
past there have been problems, but we've
really invested considerable resources in
enhancing that program and better
communications with the counties.

SENATOR RIVERA: So you -- okay. I
mean, I think that it's pretty well
established that the work that you do is at
the back end, not the front end, so to speak.
So what we're trying -- what this is
supposedly trying to fix is the front end,
meaning when the determination of eligibility
is made, as opposed to the back end, which is
what you have a role in auditing and making
sure that everything is copacetic. Correct?

INSPECTOR GENERAL ROSEN: Yes.

SENATOR RIVERA: All right. Thank you
so much.

CHAIRWOMAN KRUEGER: Thank you.

CHAIRWOMAN WEINSTEIN: Assemblyman
Abinanti.

ASSEMBLYMAN ABINANTI: Thank you,
Madam Chair.

Thank you -- is it -- am I supposed to
call you "Inspector" or "General"?

INSPECTOR GENERAL ROSEN: Dennis is
fine.

(Laughter.)

ASSEMBLYMAN ABINANTI: Okay, I'm Tom.

Thank you for your presentation. I'd like to go to the last point that you made.

You were talking about the OMIG's responsibility for program integrity. I understand you've done a pretty good job at preventing fraud and waste and catching fraud and waste. But doesn't that also include making sure that they provide the services that their contract says they're supposed to provide?

INSPECTOR GENERAL ROSEN: We do do audits that touch on that very -- actually, very significantly. So, for example, we'll -- we don't get involved in individual litigation over whether or not a service should be provided or those kinds of administrative --

ASSEMBLYMAN ABINANTI: Well, no, let me go right to the point here.

INSPECTOR GENERAL ROSEN: But what we do do is we'll look at billing and we'll see
to it that the services were properly
provided that are claimed in the billing.

    ASSEMBLYMAN ABINANTI: Okay, but do
you look at contracts? Here's my point. The
previous witness admitted that the number of
physical therapists and occupational
therapists and speech language pathologists
in the insurer's networks have been found to
be low. She also admitted that they have
found that insurers do not have adequate
policies and procedures in place for
compliance with the mental health parity law.

    Now, these seem to me to be violations
of the contracts that these entities have
with the state. Do you do any compliance
review to make sure that these places are not
being paid for individuals who are part of a
managed care plan, let's say, and yet the
plans don't offer the services that they said
to the state they were going to offer?

    Now, an individual will sign up for an
individual plan and they'll say, Oh, great, I
can get all of these services. They get
there and they find out, well, you know what,
there are no therapists available, the few
that are on the list are now booked solid.
And to me that's a fraud on the state and on
the individuals to misrepresentation as to
what they were going to offer.

Do you look at that at all?

INSPECTOR GENERAL ROSEN: If

somebody's not receiving the services they're
supposed to get, we definitely will look at
that. We look at compliance programs --
although that's more toward internal control
sorts of things. But that's a part of the
internal control reviews.

Generally what we don't get into is --
and again, this is more administrative
proceedings that have nothing to do with
us -- situations where there's a disagreement
over whether or not a medical service is
necessary or should be provided.

ASSEMBLYWOMAN ABINANTI: No, no, I'm

not saying that. What I'm saying is somebody
joins a managed care plan because there's a
whole panoply of services, and then they
become part of the plan and the services
aren't there. Do you look at that?

INSPECTOR GENERAL ROSEN: That is something we would look at.

ASSEMBLYMAN ABINANTI: Have you done any reports on your reviews of those?

INSPECTOR GENERAL ROSEN: We've done audits that talk about services not being provided even though there's billing for the services. But we haven't -- we don't focus on you have to give this person this service.

ASSEMBLYMAN ABINANTI: No, no, not on the individual service.

INSPECTOR GENERAL ROSEN: That has not been our focus.

ASSEMBLYMAN ABINANTI: I'm talking about actually being available, you know. Because I've heard the reports of people saying I'm part of a managed care plan, I go to ask for this service, there's nobody available.

So it seems to me that's a misrepresentation, and your predecessor in that seat admits that there aren't enough therapists, et cetera, et cetera, in these
plans.

So who is in charge, in this
government, with looking at the contract
compliance -- when an entity gets a contract
for being a managed care plan in the State of
New York, who is charged with making sure
that they actually have available to people
the services that they say they have? I'm
not talking about individual people, whether
they get them or not, I'm talking about
they're just not available. Who's looking at
that for the State of New York?

INSPECTOR GENERAL ROSEN: If we
received a specific complaint that a service
should be available and was not available,
that was something we would act on.

We don't do general complaints -- we
don't do general reviews to see how many
different kinds of professionals, for
example, are working for a managed care plan.

ASSEMBLYMAN ABINANTI: Well, how do we
get you to do that?

INSPECTOR GENERAL ROSEN: We would
investigate an individual complaint. The
more general issues with respect to staffing
we see as more a DOH area.

ASSEMBLYMAN ABINANTI: I would just
like to ask that in the future you look a
little bit more towards the substantive
contract compliance, because we're relying on
these entities and we're paying these
entities to be available and to provide
services. And if not they're there, as the
previous witness said they're not there, then
the State of New York is being defrauded and
the people are not getting services.

INSPECTOR GENERAL ROSEN: No, there
would be an issue that we would look at,
because there's a capitation payment being
paid for that enrollee, for that recipient.

ASSEMBLYMAN ABINANTI: Exactly.

INSPECTOR GENERAL ROSEN: And if
they're not receiving the service, that is an
issue that we can look at.

And again, we have looked at issues
where there's billings and you haven't
received the services.

CHAIRWOMAN WEINSTEIN: Thank -- thank
you. Senate?

CHAIRWOMAN KRUEGER: Thank you.

Senator James Seward.

SENATOR SEWARD: Thank you.

Mr. Rosen, I notice that the Executive proposes 69 FTEs, additional FTEs for your unit. And could you describe for us just what these 69 new FTEs will be doing?

INSPECTOR GENERAL ROSEN: This is something that --

SENATOR SEWARD: And the need for them?

INSPECTOR GENERAL ROSEN: I'm sorry, this is something that is very recent, by the way. And I can't give you a breakdown of what every one of the 69 people would be doing, because we're discussing various initiatives right now. And we'll be consulting with DOH on that further also.

I can tell you generally that I think it's a recognition of the work we've been doing -- for example, the $2.8 billion that the program got last year because of our cost avoidance and recovery efforts, and the
understanding that if we're given more resources we can accomplish more, and I'm absolutely confident that we can.

One area that we'll be doing a lot in, we'll actually be putting together a specific unit that involves managed care. And earlier in my testimony I talked about the statute that was passed last year, and in fact I frankly want to take this opportunity to thank you for enacting that statute, because I think it really is going to make a huge difference in terms of seeing to it that the managed care industry is efficient and compliant with the rules of the Medicaid program.

And under the reviews now that we've started to conduct under the legislation that was passed last year, we're looking very closely at their compliance with their contractual obligations, and those are set forth very, very clearly in the statute. We talk about it on our website. We're looking at things like do you have a adequate recipient restriction program. Do you --
have you jettisoned from your provider
network providers who have been excluded from
the Medicaid program, either at the federal
or state level? We look at things like that,
and we're going to be grading them. And
based on the grade that they get for
compliance with the obligations that they
have signed a contract with respect to, we'll
determine whether or not there's a recovery
to be made.

So that that is an area where we'll be
putting together a specific unit that will
focus very much on managed care. Now it's
more divided throughout the agency and
different functions.

Another area where we've been trying
to enhance our efforts -- and this will be a
great help with respect to that -- is doing
more with data: Data analysis, data mining,
having access to different kinds of data.
Because that's really, today, where the
healthcare industry and the regulation
therefore is headed.

So those are some of the areas. But
what we also do, so people can keep track of
our efforts and where we're focusing, is we
on our website post our work plan. It comes
out in April, but we actually constantly
update it throughout the course of the year.
And as program focuses and emphases develop,
we'll be modifying the work plan so people
will be able to keep track of where we're
focusing.

SENATOR SEWARD: Thank you for your
answer. I had a couple of other questions I
wanted to get to.

What is your reaction to the recent
revelation from the State Comptroller, their
audits at the State Comptroller's office,
that Medicaid improperly reimbursed
$700 million? That's a big number.

INSPECTOR GENERAL ROSEN: The -- the
audits -- we're very familiar with those
audits. We work very closely and
collaboratively with OSC. Those audits cover
about a three-or-four-year period, and they
involve different areas.

Some of the areas that they involve
we're not involved with. For example,

Medicare Plan B was one of the focuses of one
of the audits that they referred to, and we
have nothing to do with that.

There are a couple of areas that we
are active in, and with respect to those
areas, we had ongoing audits at the time that
OSC started looking at it. We reviewed their
findings, we acted on them. So there was
nothing particularly surprising about their
audits, and I think we have a good
collaborative relationship with them.

But again, I want to emphasize that
this was over a period of years. This wasn't
something that just happened yesterday.

SENATOR SEWARD: One quick question.

Does your agency have a recovery target for
this year? Do you go for targets?

INSPECTOR GENERAL ROSEN: The recovery
target is still under discussion because,
again, the proposal to increase our FTEs is
relatively recent, and so we're still talking
about that.

SENATOR SEWARD: Thank you.
CHAIRWOMAN KRUEGER: Thank you.

Assembly.

CHAIRWOMAN WEINSTEIN: Thank you.

Assemblyman Byrne.

ASSEMBLYMAN BYRNE: Thank you.

And thank you, Inspector General, we'll go by that. Or Dennis, is that the right name? Thank you for being here today and your patience.

Just to kind of follow up on what you were just saying, it was going to be one of my questions, referencing the press releases from the State Comptroller's office over the past -- not just this very recently, but the past several years. It does seem that waste, fraud and abuse becomes a bit of a political cliche, but we know it does exist. And after hearing your testimony and reading it, it's encouraging to see that there is a lot of good headway that is being made.

But I was hoping you could go into a little bit more --

INSPECTOR GENERAL ROSEN: Could you speak up more into the microphone, please?
I'm sorry, but I have trouble hearing --

ASSEMBLYMAN BYRNE: No, no problem,
sir. Is that better?

INSPECTOR GENERAL ROSEN: That's much
better.

ASSEMBLYMAN BYRNE: Okay. To follow
up on what Senator Seward was just speaking
about regarding the State Comptroller's
office report, it was something I was going
to ask as well because it's something that it
becomes cyclical. It's like every year
there's a release, and this one was very
recent, $800 million.

And it's encouraging to know that your
office does collaborate with the State
Comptroller's office. I was going to ask if
you could elaborate a little bit more on
that.

And also it's encouraging that while
it becomes a little bit of a political cliche
when we talk about waste, fraud and abuse in
a state program, that we're actually finding
it and are doing something about it. I just
feel like we should be able to do more.
My question is, first, if you could elaborate on how you collaborate with the Comptroller's office. Two, if the numbers that you put in your testimony, if there's any overlap with the savings that the Comptroller's office has identified.

And something that's been talked about when we were speaking about the Medicaid Redesign Team and the cause for the increasing costs in Medicaid -- have you identified any examples of waste or fraud in things like the Consumer Directed Assistance Program or anything like that? If you could just explain that a little bit, I would appreciate it.

INSPECTOR GENERAL ROSEN: Okay.

The -- well, to take it one at a time, we do work very closely with OSC. We have people who regularly communicate with them, review their audits, discuss -- they often ask us how we do things, and that impacts how they do things.

Very often their audits do have suggestions that we think are very helpful
and we might follow through on those suggestions. And again, often the work does overlap. We very often -- again, as I said earlier, when they start an audit, we've already been involved in that area, so it ends up collaborative and a partnership.

With respect to -- what else -- what would you like me to answer next? You asked two more.

ASSEMBLYMAN BYRNE: The numbers you cited in your testimony about the --

INSPECTOR GENERAL ROSEN: The recoveries, the 2.8?

ASSEMBLYMAN BYRNE: Correct. Does that include anything that the Comptroller released?

INSPECTOR GENERAL ROSEN: That does not include the Comptroller's efforts.

But what happens is we go out and we'll usually follow up on the audits and we'll make the recoveries and yeah, to that extent it does include it.

When they come out with a report, they say "We think we've found something here,"
but it's always us who does follow up. So yes, in that sense it does include their numbers. But we're doing the work. We do the follow-up. Compared to what we do, theirs is a much more limited look, and then we follow up.

ASSEMBLYMAN BYRNE: Yes. And then thirdly, I was just curious, I know they do -- it's a -- they do great work for a lot of people, but have you identified any waste or fraud specifically within the CDPAP program at all?

INSPECTOR GENERAL ROSEN: There -- there's -- there are -- I mean, the program, as you know, is so huge, there are going to be problems throughout different areas of the program. And yes, there have been problems with consumer directed programs. In fact, the federal government has pointed that out from time to time. Health and Human Resources' Office of the Inspector General has issued a couple of reports regarding consumer-directed healthcare.

And we get complaints on it; we also
do audits on it. We do regular audits on it, and we've had recoveries. And so that's one of lots of areas where there are issues.

ASSEMBLYMAN BYRNE: Great. Thank you, sir.

CHAIRWOMAN KRUEGER: Thank you.

Senator Gallivan.

SENATOR GALLIVAN: Thank you. Can you hear me okay?

INSPECTOR GENERAL ROSEN: Yeah, if you get a little closer. Sorry, but the echo is loud.

SENATOR GALLIVAN: The Consumer Directed Personal Care Program, what do you do in that particular area to ensure the fiscal integrity of the program?

INSPECTOR GENERAL ROSEN: We will audit to see if services were actually provided to somebody, for example. We will audit to see if the provider might be the actual individual providing the services -- the aide, for example, might be billing -- doing duplicate billings, filing, in effect, for being in two places at the same time with
two different recipients. Sometimes there
are quality of care issues that may arise,
which we may see as more of a law enforcement
issue, maybe our investigators will talk with
law enforcement about that.

And obviously, because -- I mean, it's
a very laudable program, you've got people
taking care of people that they know very
well, sometimes they're relatives, but
obviously that can also lead to issues that
may go to the heart of program integrity
where you've got people who are related and
it's federal money that's being spent.

So those are the kinds of issues that
arise with respect to consumer-directed care.

SENATOR GALLIVAN: So the program has
grown substantially over the past several
years. Have you been able to keep up with
it?

INSPECTOR GENERAL ROSEN: Yes. Yes.
Particularly, again, as has been referenced
in some other statements, with the aging
population in particular, you know, the home
care is a way to keep people out of
institutions.

SENATOR GALLIVAN: You have enough people, you have enough policies in place, you have enough tools to be able to keep up with that particular program?

INSPECTOR GENERAL ROSEN: Well, we're frankly very excited about the proposal to increase our staffing, because we are very, very confident, and I think our record bears this out, that we will make very good use of those added staff, and that will increase our recoveries and it will, again, increase overall I think the efficiency of the program.

We've emphasized more cost savings than we have in the past -- and those are real, by the way. For example, a large portion of the cost savings is where we find an insurer who should be paying a claim rather than somebody going to Medicaid. So that we can show anybody who asks that our cost avoidance numbers are very, very reliable. And that's been an added emphasis for us.
And again, as I mentioned earlier, we're using more and more data to get to the information that we need, because there's a treasure trove of information that's collected with respect to Medicaid.

So I do think that the addition of the FTEs that we should be getting this year will help us immeasurably. And again, I think our past record shows that we use our resources well.

SENATOR GALLIVAN: Thank you.

INSPECTOR GENERAL ROSEN: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Assembly?

CHAIRWOMAN WEINSTEIN: No one.

CHAIRWOMAN KRUEGER: Oh. I might just have one or two questions for you, Dennis. Thank you for being here.

I know this isn't your bailiwick, but you're so good --

INSPECTOR GENERAL ROSEN: I'm sorry,

I'm having trouble hearing you.

CHAIRWOMAN KRUEGER: I'm sorry. I said this question is not about Medicaid
fraud, but I know that you have developed all kinds of systems for tracking patterns of abuse, and that's why your agency --

INSPECTOR GENERAL ROSEN: I'm sorry, for tracking what?

CHAIRWOMAN KRUEGER: Patterns of abuse.

INSPECTOR GENERAL ROSEN: Yes.

CHAIRWOMAN KRUEGER: Okay, sorry, get really close. Thank you.

So you have all this talent on your staff that can help find out when bad things are happening. So I'm working on a different issue with my staff, and actually the Governor made reference to it in his budget, which is tracking down healthcare providers who are in fact perhaps guilty of sexual harassment or abuse, may have been found guilty in another state, may have not been correctly tracked from a court case through the Office of Professional Licensing, through the office that tracks doctors specifically within Department of Health.

And I know I have been talking with
the court system about -- they of course know
when a doctor is found guilty of something.
They don't think they're supposed to
necessarily report that somewhere. And then
you've got separation between licensing
through Adult Professions in SED, but also
some tracking within DOH.

I guess it's more of a question do you
think if I asked the Governor to let you take
a look at all this you could help us figure
out how, when there are bad players -- and
I'm not saying there's a huge number of them,
but we keep finding cases where they were
given a license even though they had lost
their rights in other states, where they were
found guilty in our courts of abuse and
harassment, but they were just allowed to
continue to practice.

It just seems to me we don't have a
system in place to make sure that we are not
allowing bad apples to continue to practice
medicine. And I think that you and your
staff might be the right ones to take a look
at and propose a better system for tracking.
INSPECTOR GENERAL ROSEN: We -- I mean, that's the kind of thing I'd be happy to discuss.

We do have some systems in place for tracking some of the kinds of behavior you're talking about. We work very closely with law enforcement. And, for example, if there's a conviction involving, say, a medical professional, we typically -- we will know about it, and we will exclude that person from the Medicaid program.

The Justice Center sends us referrals. You know, you mentioned cases of abuse, for example, of harassment. Very often the Justice Center gets those kinds of reports, and they have an obligation to refer those kinds of complaints to us.

So that, again, I'm always happy to discuss enhancing the system. But those are just a couple of examples of how we are involved in a significant way in those kinds of issues right now.

CHAIRWOMAN KRUEGER: Okay, thank you. I'm going to follow-up with you then after
the hearings are done. Thank you.

    INSPECTOR GENERAL ROSEN: That would be fine.

    CHAIRWOMAN KRUEGER: Okay, I think we are done. So thank you very much for being with us today.

    INSPECTOR GENERAL ROSEN: Thank you.

    CHAIRWOMAN KRUEGER: Thank you.

Our next -- we have finally now completed the government representatives, for people keeping score. We have our first panel. Again, from now on, for the rest of the duration of the hearing, each separate agency gets five minutes. So if it's a panel of two different agencies, they each get five minutes. And the questions will be three minutes from the legislators unless they are the chair of the relevant committee, they get five minutes. Okay?

    But again, for legislators, there is no group who are sitting here who want to testify who won't be happy to follow up with you after a hearing if you want to get more information from them. That's why they're
here. So even though we are making the
timeline short because we have -- for those
tracking, we have four more pages of people.
We're here because we're interested. The
testimony goes up online. And seriously, if
you're in this audience and there's any
legislator that seems to voice interest but
we cut them off, you find them. That's what
you want to do, so you find them and follow
up with them.

So good afternoon to the Healthcare
Association of New York, HANYS, Bea Grause,
and also to Greater New York Hospital
Association, David Rich.

MS. GRAUSE:  Great. Good afternoon.
CHAIRWOMAN KRUEGER:  Good afternoon.
MS. GRAUSE:  Good afternoon. I'll
start out.

Chairs Krueger, Weinstein and Rivera,
and other members of the committee, my name
is Bea Grause. I'm president of the
Healthcare Association of New York State.
And thank you for this opportunity to discuss
our '20-'21 Executive Budget proposal.
As I have found myself saying many times recently, there are no simple solutions to complex problems. But that said, we believe that the reasons for this staggering $2.5 billion state Medicaid gap are quite clear.

First of all, healthcare workers need a liveable wage. Second, demand for healthcare services is increasing, in part due to our aging population and, as has been mentioned before, increased enrollment. We do absolutely stand ready to help close this gap and agree with the Governor's parameters around helping to protect beneficiaries as part of that effort. Our goal, as the state's hospitals across the state, is to preserve access to care for all by keeping our doors open.

Hospitals generally across the state are the heart of their community. They are often the largest employer. Collectively, our hospitals produce $170 billion as one of the state's largest economic engines.

Our hospitals and nursing homes across
the state are financially vulnerable, and
cutting provider payments will cut them to
the bone. I think for the MRT process, our
logic and our priorities are to protect
funding, which in turn protects jobs. And
healthcare is primarily people taking care of
people. Sixty percent of a hospital's --
more than -- two-thirds of a hospitals budget
is largely related to payroll, and for
nursing homes about 80 percent or more are
related to payroll. So those jobs really are
the people taking care of the people.

So we want to protect that funding.
We certainly want to focus on the cause of
the deficit, as I alluded to before, and we
believe looking at the structure of the cap,
the global cap, needs to be looked at.
Healthcare spending has exceeded general
economic growth for decades, so I think not
only does the cap need to be raised, but also
the mechanics of the cap need to be addressed
as well.

We certainly support the managed care
provisions in the Governor's budget and will
help to work those in through the MRT process as needed. And if new revenues arise in the budget process, we think that they should also go to close the Medicaid gap.

And in closing, our hospitals and nursing homes again stand in partnership with our physicians, our nurse caregivers. And together we have made significant progress in quality and patient safety and cost containment, and we want to continue together to take New York State forward on healthcare reform and will participate in the MRT to help make that happen.

Thank you.

CHAIRWOMAN KRUEGER: Thank you.

MR. RICH: Thank you. Good afternoon.

First I'd like to commend the Governor for once again impaneling a Medicaid Redesign Team. Ever since 2011, he has made clear that collaboration works better than confrontation when it comes to Medicaid policy and that if we are to make hard decisions, they should be made together, with expert input and, most importantly, with the
goal of protecting Medicaid beneficiaries and communities. We look forward to working with the Legislature and the MRT.

But make no mistake, we confront a huge challenge. The MRT has been charged with finding 2.5 billion in Medicaid savings for the next fiscal year. To give you a sense of the magnitude of this, if there were an across-the-board cut to all Medicaid payments to achieve 2.5 billion in savings, it would require a 10 percent cut in Medicaid payments to every hospital, nursing home and every Medicaid provider in the state.

And the actual impact would be a $5 billion cut, as you know, since the federal matching dollars would be cut as well. A $5 billion across-the-board cut to all providers would absolutely force hospitals, nursing homes, clinics and other providers to close. So we are all facing a huge challenge, and we must find alternatives.

We will judge the outcome of the budget process according to the following
five principles. First, any new revenues
must be dedicated to Medicaid. If revenues
become available from settlements, tobacco
taxes, revenue reestimates, rainy day funds
or other sources, they must be dedicated to
Medicaid. Hospitals and other safety-net
providers, and the patients they serve,
should not be cut if other revenues can
lessen the impact.

Second, the Medicaid global cap must
be reformed. The cap, as you know, came out
of the first MRT in 2011, but at that time we
had approximately 4 million Medicaid
enrollees. We now have more than 6 million,
and yet the annual global cap increase has
actually gone down from 4 percent in 2011 to
2.9 percent today.

And there have been unintended
consequences. Because there was no
adjustment for enrollment in the cap,
hospitals and other providers went a decade
without a Medicaid rate increase, so Medicaid
rates now cover only 72 percent of costs,
many of our safety-net hospitals.

The global cap should be reformed so the legitimate growth due to enrollment, aging and other factors are taken into account.

Three, the true drivers of growth must be reformed. Many people have talked today about the fact that the Managed Long Term Care Program is one of the main drivers of growth, and any serious solution to the problem must address that program.

Fourth, if there are hospital cuts, safety-net providers must be protected. Hospitals with high volumes of Medicaid patients are disproportionately harmed by Medicaid cuts. There are already 30 hospitals on the watch list for closure who rely upon regular state support just to keep the lights on. Other hospitals are also on the brink. It makes no sense to cut Medicaid rates for the hospitals with one hand just to bail them out with the other. They and their communities need to be protected.

And finally, if there are hospital
cuts, the state should find ways to help hospitals weather them. In this vein, we strongly support the provisions in the budget that would put an end to some insurance companies' bad behavior. Insurers deny payment for medically necessary services that consumers have paid premiums for. And so we urge you to support the insurance reforms that are in the Governor's budget. I've added to my testimony a summary of those reforms.

Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Senator Gustavo Rivera.

SENATOR RIVERA: Good afternoon, folks. Thank you for your patience.

There's a couple of things that I'm glad that you folks went on the record -- certainly David, and I'm not sure if Bea, on behalf of HANYS, also agrees with some of this -- but as far as the global cap must be reformed, I guess that there's agreement about -- and I agree with you a hundred percent. As far as any new revenues must be


dedicated to Medicaid, I agree with that as well.

However, I just wanted to ask a general question about you did speak about revenues become available from settlements, reestimates, higher than expected rainy day funds, or other sources. Is either HANYS or Greater New York taking a position on the possibility of raising revenues by taxing wealthier individuals?

MR. RICH: We have not, no.

SENATOR RIVERA: Okay.

MS. GRAUSE: We have not either.

SENATOR RIVERA: Just had to check.

However, the "other sources" is in there, so I would agree with you if we have the biggest hole, that we should certainly plug it with that money.

If there are hospital cuts, safety nets must be protected, I absolutely agree with you there, and I'm guessing that there's agreement between the both of you.

All right. So let's talk a little bit about MRT. It is immediately after the
governmental representatives speak, then you folks come up, which certainly speaks to the importance of the organizations that you represent and the entities that you represent across the state. Have you been approached officially by anybody in the Governor's office related to membership of either your organizations in the MRT?

MR. RICH: We have not, no. We haven't been asked to be on the MRT.

SENATOR RIVERA: Would you agree with me that -- I keep saying the date because I can't really believe it, that it is January 29th and that we have, according to -- certainly you have experts in both of your organizations that have read the same documents that we've read and have done the analysis yourselves. So is there something -- and I'm sure that you've been here all day, without -- I obviously have a very strong opinion about certain things, but without the extra sass, if you will, was all the conversation that we had related to what was in or not in the documents accurate?
Related to is the -- is there anywhere that your folks found any sort of reference to what the MRT would actually do, the timeline of it, the membership -- was there anything in the documents that you saw that I didn't?

(Overtalk.)

MR. RICH: I don't think so. I think you read the provision earlier.

SENATOR RIVERA: Yeah, I just want to make sure. Would you agree, particularly considering the seriousness of the crisis that you both acknowledge in your testimony here, that we probably would need more time to really consider this, and we would need more participation certainly from both of your organizations and certainly from the Legislature, to actually try to solve this problem? Would you agree that that would be the best way to achieve this?

MS. GRAUSE: I think -- you know, I think you are bound by the deadline of the budget for March 31st, and I do think that progress will be made. There are -- there
will be many ideas, I'm sure, put on the
table that will go into the budget that will
not be entirely complete or as completely
thought out, I guess, as they need to be, and
that will continue after April 1st. Because
I think -- again, I think the challenges
around the cause of the Medicaid gap are
related to demand and how to provide -- and
largely how to provide services more
efficiently, and that will take time to
figure out. So we'll move into another phase
I think.

SENIOR RIVERA: Would you agree that
it would be easier to figure all that out if
there was full information provided by the
administration about the causes of the crisis
and the cost drivers and how they calculated
some of these proposals -- would any of that
be helpful to you or to us?

MS. GRAUSE: I think -- I think -- I
think -- candidly, I think we talk -- we work
on that 12 months a year. So I think we
generally understand that. And I do think --

SENIOR RIVERA: I only have --
MS. GRAUSE: -- one of the good things that -- I think there's goodwill about trying to get that information. I just don't think it's all available in one place.

SENATOR RIVERA: All right, gotcha.

So I -- and I will acknowledge this -- I only have 40 seconds -- I will say I am thankful that you are looking forward to participating in this process, that you're willing to do it. I'm not sure -- you're seeing goodwill, I'm not necessarily seeing it. I would prefer information to goodwill. And call it bad will if you will, but just tell me where -- what we actually have to deal with.

But I'm certainly looking forward to eventually, when we actually have the MRT reshaped -- and maybe you'll be on it, maybe I'll be on it, maybe there will be representatives from the Legislature. I hope that we have an opportunity to kind of work on this, since I know the seriousness of the crisis. And I'm looking forward to working with you regardless, because there's always been goodwill from y'all to us. Maybe not
some other people. Thank you.

MS. GRAUSE: Surely.

CHAIRWOMAN KRUEGER: Thank you.

CHAIRWOMAN WEINSTEIN: Assemblyman Cahill.

ASSEMBLYMAN CAHILL: Thank you, Madam Chair.

Hello and welcome. It's good to see you.

MS. GRAUSE: Thank you.

MR. RICH: Thank you.

ASSEMBLYMAN CAHILL: I don't have any specific questions that will require anything other than your reaction. And I'll start with this.

What if every single part of the Governor's budget proposal and all the likely things that will come from the MRT were to become a reality? What would happen to the hospitals in New York State as a result?

MS. GRAUSE: Do you mean if there was a $5 billion reduction, is that what you're asking? Just want to --

ASSEMBLYMAN CAHILL: Well, if that's
what the Governor's budget proposal would --

MS. GRAUSE: Then that would be the impact, that would be the impact on providers.

Again, I think as David alluded to before, I think we have all different types of hospitals across the State of New York. Whether you're a small rural hospital or a large academic hospital or a -- the world's largest public hospital, they are all structured very differently, they all see -- they -- you know, healthcare -- politics is local, healthcare is local. And they are a reflection of their communities. And particularly in low-income communities, both low-income rural and urban, those hospitals would be devastated. It would be very difficult to keep their doors open.

ASSEMBLYMAN CAHILL: I believe your written testimony indicates that about half of the hospitals in New York State are operating with a negative balance right now.

MS. GRAUSE: Yes, that's correct.

ASSEMBLYMAN CAHILL: If they're
already operating at a negative balance and
they see reduced Medicaid, if they see
reduced other hospital subsidies, if they see
increased costs for medical malpractice, if
they find a tax on their capital
improvements, how do they survive?

MS. GRAUSE: Well, hospitals --
hospitals are constantly working to make a
margin. And so to reduce their expenses, you
know, and try to make sure that they have
enough resources to restore their equipment
and buildings and tools that physicians and
nurses need -- so the expense pressure is
tremendous, but they're trying to reduce that
expense pressure as much as they can and find
new ways and more efficient ways to provide
services so that they can generate a margin
at the end of the day.

All of our hospitals are
not-for-profit. And again, I think,
depending on their comparative financial
health, they are all trying to become more
efficient over time. It's just difficult in
a very short period of time, if you're going
to have a significant rate reduction, how you recover from that in such a short period of time.

And that's why I think we support the Governor's proposals around managed care. And we've -- last year and again this year are looking for things like regulatory relief, CON relief, workforce flexibility that would help reduce that expense burden for hospitals. Again, make it easier for them to maintain a margin.

MR. RICH: But I think that's why your question is very well taken, and that's why we believe that the number needs to come down from where it is, because there's no way that the provider community can take a $5 million cut, let alone the patients and the residents that they serve. And also why we need to protect safety-net institutions, many of whom would be in the 50 percent that you mentioned.

But also we hope we can find alternatives to the usual types of just sort of slash-and-burn cuts that governors have
put out in the past, and that's why again I think it's -- we're supportive of the idea of having the group come together so we can find some alternatives.

MS. GRAUSE: And again, if I could just add to that, you know, if it was easy to do, we would have done it already. We're all taxpayers, we're all consumers, and we all want to make healthcare more affordable for everyone. It's good for the economy.

And so I think the MRT process will help us to have that dialogue. Again, I think -- I know it will be challenging. And I know there's no easy answers. But I think there's a lot of goodwill to try to at least have that dialogue.

ASSEMBLYMAN CAHILL: I would just piggyback on Senator Rivera's comment that, you know, there are many, many things in your memos and in your testimony, written and oral, where you've indicated support and concern about different positions. But on the question of general revenue, I think there's been a little bit of silence. And it
would be very important for us to hear from those folks who are responsible, oftentimes the largest employer in our community, certainly entities that we rely upon for our times of need, to register in and say this is the real choice that our taxpayers are facing in New York State. And it would be great to hear from you on that front.

Good luck. We're going to do the best we can for you through this budget process.

MS. GRAUSE: Thank you very much.

MR. RICH: Thank you. Appreciate it.

CHAIRWOMAN WEINSTEIN: Senate?

CHAIRWOMAN KRUEGER: Senator Robert Jackson.

SENATOR JACKSON: Good afternoon. Can you hear me?

MR. RICH: Yes.

MS. GRAUSE: Yes.

SENATOR JACKSON: Thank you for staying the course.

I don't know if you were here earlier when I raised some questions to the commissioner and especially about the new
team that's going to be developing. I don't know what it is, all I know is that the Governor said that there's going to be two individuals, there may be more. I hope that some of the advocates are on there and people with knowledge about the system itself.

But with respect to the Greater New York Hospital Association, I have a huge hospital in my district, Columbia Presbyterian New York Medical Center, which is a big conglomerate of -- and I'm concerned about the impact it's going to have on them, I'm concerned about -- earlier I talked about Isabella Geriatric Center and small hospitals and small nursing homes.

So I can't visualize, and maybe you can help me do this, how are we going to make those huge cuts and the services are not going to be cut? Just -- that doesn't match with me knowing that if you're going to have to deal with that, obviously we're going to have to reduce services or somehow we're miracle workers. And so I just want to know from your perspective, from the advocacy,
from the hospitals and New York's health associations, sort of paint a picture for me:

How can we do that?

MR. RICH: If there are huge cuts,

there will definitely be service cuts.

There's no question.

So, you know, one of the tasks given to the MRT was to have no impact on beneficiaries. But as I mentioned before, if you got to the end and then we're at a 10 percent across-the-board cut to every hospital and nursing home in the state, there would absolutely be an impact on beneficiaries.

So we need to try to find solutions that are different, that are structural reforms that can work over time. But I also think, you know, as I said before, we need to bring that number down so that there are not huge cuts that will really have terrible impacts.

SENATOR JACKSON: So this is to be continued.

And the chair of the Health Committee,
Gustavo Rivera, had indicated: Do you think that really between now and the budget there's enough time to do that, considering the complexity of it, and understanding the goal is, as the Governor said, is to cut the budget but continue the services that we're providing? And quite frankly, I don't see how we can do that.

And so I'm willing to listen and to observe, but I'm just curious.

MS. GRAUSE: I do think ideas will be generated by April 1st, but I do think the implementation of those ideas will take time, I think as David alluded to. So it will go beyond April 1st, but the ideas -- we can generate ideas before then.

SENATOR JACKSON: To be continued.

Thank you.

CHAIRWOMAN KRUEGER: Thank you.

CHAIRWOMAN WEINSTEIN: Assembly Ra.

ASSEMBLYMAN RA: Thank you.

Just wondering if you can just give some thoughts on the surcharge for Certificate of Need that's proposed in this
Executive Budget proposal.

MS. GRAUSE: It's an expense. I mean, I think as was -- the commissioner testified earlier that 3 percent will be assessed on the capital costs of a hospital's application, or the cost of the application, unless those funds were granted from the state originally.

MR. RICH: Yeah, we're trying to work with our members to understand what projects do they have coming up and therefore what would this new fee mean in terms of adding significant cost onto those projects. And so we will have a more full understanding of it that we'll be able to get back to you with.

ASSEMBLYMAN RA: Okay. Because I think definitely, you know, in part of the state, but particularly downstate with the cost of construction and everything involved in that, you know, adding on an additional cost when we have I think needs that our hospitals are seeking to meet by engaging in new construction, anything that's going to create a disincentive to that I don't think
is going to ultimately serve the public or
the patient.

So if you have further information as
your members are going through it, I'd
appreciate if you can share them with us.

MR. RICH: Absolutely.

MS. GRAUSE: Certainly.

ASSEMBLYMAN RA: Thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Senator Ritchie.

SENATOR RITCHIE: I represent a very
rural area in the North Country. We have
very rural hospitals and nursing homes. Many
of the hospitals and nursing homes that when
I started nine years ago were solvent and in
the best shape are now teetering on potential
closure. You're talking about possibly
cutting services? Many of the hospitals that
I represent, they don't have a lot of the
services that other hospitals have, they have
the basic services. I don't really know what
else they could possibly cut out.

So I guess my question is
hypothetical. If a cut like that goes into place, how many potential hospitals or nursing homes are going to have to close their doors?

MS. GRAUSE: I just want to be clear, we don't support -- we support reducing that $5 billion in order to avoid cutting services. So we are absolutely going to work as hard as we possibly can to make sure that hospitals and nursing homes and other providers can keep their doors open, can maintain their services, and make sure that they are taking care of the needs of their communities across the State of New York.

So that's what we're coming to the table with and trying to make sure that we can try to achieve that through some problem-solving and creative thinking, and potentially new revenues, and as I said to Chairman Cahill, through ideas that would help to reduce the expense of providing those services so that our non-for-profit providers could maintain a margin. So that's what we're really hoping to avoid.
And again, I think we know we have a -- I know it's a challenge, and that's a big number, but again, I think we are going with the hope and intention that we can be creative in terms of reducing the expense of delivering care, and perhaps finding more efficient ways to provide those healthcare services so providers can keep their doors open and can meet the needs of their community.

SENATOR RITCHIE: So my fear just is with any kind of cut we're going to see some significant potential closures. Because the ones that were viable a few years ago can't pay payroll now. And if they have any cuts, I don't know what's going to happen to them. And in the area that I represent there are many miles to the next hospital. Sometimes when there's five foot of snow on the ground, we need some kind of medical services in the area.

MS. GRAUSE: Absolutely. And I think as David said earlier, many of those hospitals are supported by state dollars
today, and it makes no sense to cut their
rates on one side and then having to provide
state funding from a different bucket on
another. So we completely agree with you.

SENATOR RITCHIE: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

I just have two questions -- oh, you
have another Assemblymember?

CHAIRWOMAN WEINSTEIN: Yes, a late
starter. Assemblyman Byrne.

ASSEMBLYMAN BYRNE: Yes, thank you,
Chairwoman.

So two questions really, and then I'll
just let you answer. One, I've heard you
mention revenue raisers and if there's some
specific proposals that you would like MRT II
or the Legislature to think over, if you
could get a little more specific on that.

Obviously it's always a little bit of
a touchy subject. Nobody likes to increase
taxes or fees on anybody. Same reason why a
lot of folks wouldn't want to have to pay an
additional surcharge on different capital
improvements, because it eventually can get
passed down to consumers.

But -- so that's one question. Number two, we do know who the chairs of the MRT II are, right, Mr. Dowling and Rivera. And since you're the first people up here on the dais that don't necessarily work for the government, who would you -- not necessarily a person, but one of the questions we've had is -- or concerns, is more transparency and balance on the MRT II.

So what types of industry would you like to see on there? Obviously the hospitals, and I think they have a voice there too. I personally would like to see a balance of -- a large variety of stakeholders, so everybody who is going to be affected by this has a voice. But what other types of people in healthcare or groups in healthcare do you believe should be on the redesign team?

MR. RICH: Yeah, I mean I think we would totally agree that it should be a broad group, a broad representation, including consumers, absolutely, as well as nursing
homes --

MS. GRAUSE: Labor.

MR. RICH: -- home health, labor, et cetera. And I think -- you know, I think it wasn't perfect in 2011, I think they tried to cover a lot of different stakeholder groups. But everyone's going to need to be at the table, because we need a lot of good ideas from people coming from a lot of different walks of life.

In terms of revenues, you know, I put a few examples, including rainy day funds, in there. I think from my perspective, it's raining, when you look at the Medicaid budget as it currently stands and as it was proposed. And also, you know, every now and then another settlement gets announced with a different industry by the Attorney General, and so we'd like to see some of those settlement funds dedicated to Medicaid as well.

MS. GRAUSE: Recreational marijuana is another one where if it's passed, then we think the revenues should go to healthcare.
ASSEMBLYMAN BYRNE: Okay, so that's a
good point. Because when you mention the
settlements, one concern I just have is
putting revenues that could be considered
one-shots and then putting it into something
like a Medicaid program. So you want to make
sure that if we're going to be funding it, it
should be sustainable --

MS. GRAUSE: Recurring, yeah.

ASSEMBLYMAN BYRNE: -- with our
existing revenues. And it's a great big
budget, so there's a lot of different things
we can look at. But that was just one of the
concerns I had.

So thank you for your comments and for
your time.

CHAIRWOMAN KRUEGER: Thank you. Now I
have just two short questions.

One, did you hear me ask earlier if
anyone saw something in the budget about
sweeping DSRIP? Even though we're three
years behind from the feds, but I'm assuming
you and other providers have spent the money.
Were you under the impression there was a
possible sweep of those funds if they ever show up?

MR. RICH: So I had seen -- actually in today's Crain's Health Pulse, they were reporting on the Assembly report on the budget where they seemed to indicate that for this year budget actions there were some pools that were being swept, and one of the DSRIP pools was one of them. But I have not actually heard directly from the Executive about how you actually get to the $599 million in current-year actions that they mention in the budget documents.

CHAIRWOMAN KRUEGER: And I'm going to take the leap that sweeping money people have already spent would not be very popular in the healthcare universe.

MS. GRAUSE: That's a good leap.

MR. RICH: Correct.

MS. GRAUSE: That would be a good leap.

CHAIRWOMAN KRUEGER: Thank you.

And assuming -- we all know why the Medicaid costs are going up. I don't even
know why the Governor is surprised. I mean,
everybody knew exactly what was happening and
why. Just -- it was demographic reality,

based on what happened.

So it's very hard to ask you this,
because you're the representatives of
hospitals. But is it conceivable that in
some parts of the state we actually might
have an oversupply of hospitals and we could
best address our problem of having to limit
how much we spend in healthcare by saying to
a few, sorry, there's enough here? Or saying
no to hospitals who still are wanting to
expand.

Can you ever imagine your associations
going to a place where you assisted
government with those kinds of hard
decisions?

MS. GRAUSE: So it was before my time

here in New York State, but you have already

had the Berger Commission.

But I think what is happening already,
in a very dynamic market, is that the

location of services and whether or not a
hospital stays a hospital or they close part of it and provide other parts of services, is already happening across the state. So that is actually a very dynamic part of the New York State market today.

So there's -- you know, most of the care is migrating to outpatient and now community-based services, so the delivery of care, so to speak, is becoming decentralized very quickly. So that is in fact already happening.

MR. RICH: And we have seen -- we're seeing it in Brooklyn right now in terms of the One Brooklyn project and the overall Brooklyn project where, based on actual data, they decided that, you know, Kingsbrook should downsize and provide only certain services, Interfaith should provide certain services, and Brookdale would remain a trauma center and then also try to figure out how to have capital dollars to create more ambulatory care services, et cetera. That's the kind of planned, using-data approach that we would certainly support.
And so yes, if there were opportunities with the state to really use data and figure out, particularly for very struggling institutions, what does the community need first and is what they're getting right now exactly what they need, or should it look a little bit differently, just as they've been doing in Brooklyn.

MS. GRAUSE: And I think to add to that, I would add the onset of new technologies, and that is another -- you know, again, I'm not sure we can get it all finished by April 1st, but I think there are a lot of new technologies that could benefit consumers and help them with their decision-making, really help them to understand the services that are in their communities, that could do -- could produce a result such as getting them to the right service at the right time and the right place. And that would be a positive.

CHAIRWOMAN KRUEGER: Thank you both. I think we're done with this panel. Yes, thank you very much.
MS. GRAUSE: Thank you.

CHAIRWOMAN KRUEGER: All right, next up, 1199, Helen Schaub.

Good afternoon.

MS. SCHAUB: Good afternoon. Thank you for having me.

CHAIRWOMAN KRUEGER: Thank you.

MS. SCHAUB: So, you know, in the interests of everyone's time here, certainly yours and all the other folks who are waiting to testify, I don't think I'll repeat some of the points that previous speakers have made that are in the written testimony that you have. Obviously everyone knows Medicaid is a hugely important program for patients, for consumers, for people with disabilities, for children, many -- 6 million people throughout the state.

We share the concern about the impact that really $5 billion of cuts would have on that whole system and on the people who depend on it. And certainly we share the idea that's been raised by many of you and others that there has to be a serious look at
the adequacy of the Medicaid cap.

I would certainly add to that, you know, in the framework of the cap, there is only one solution to overspending the cap, which is to cut until you get under it. And so raising the cap to acknowledge necessary expenses is the way to avoid those cuts. And thinking about how it should grow going forward is certainly the way to not be in that situation again and again.

We do think that there is value in revisiting some of the decisions, the policy decisions that were made by the MRT nine years ago. And I want to focus a little bit on the question of managed long term care, since it's come up over and over again, rightly, as one of the drivers of growth within this program.

And the point that we'd like to make is that there are some structural incentives built into that program that we think have driven extraordinary growth. I mean, the population is aging, absolutely, and it's one of the reasons we have to do everything we
can to make the Medicaid program as efficient
and as effective as possible, because there
will be increasing need and increasing
pressure for services under the Medicaid
program.

But under the -- the population, for
example, if you think about people over 85
who are likely to need long-term-care
services, that population in New York State
is growing about 3 to 4 percent a year. But
the Managed Long Term Care Program has been
growing 13 percent a year, even after all of
the mandatory populations were absorbed. So
we think there is a disconnect there, and it
has to do with the financial incentives that
were built into the plans.

Originally when the MRT came up with
this care-management-for-all idea, their
vision, explicitly laid out, was to move
people into fully capitated or fully
integrated managed-care plans that would
manage both the Medicaid and the Medicare
spend. And, you know, for people who are --
who need a lot of services, there is some
logic to that. If you invest more in the
long-term-care services, you have
high-quality home care, you keep people out
of the hospital, you actually are able to
capture that savings from Medicare.

But what happened is the state set
up -- you know, tried to do that, set up this
fully integrated duals Advantage program.
They didn't do that very well, there were a
bunch of missteps in how it got set up. It's
now shut down, as of the end of last year.

So the vast majority of folks who are
dually eligible, Medicare, Medicaid, need
long-term-care services, are in what's called
a partially capitated program. It only
manages the Medicaid spend. The vast
majority of the spend there is home care
services. Because nursing home has been kind
of in and out, but mostly at this point out.

So if you're a managed long term care
plan and you have a capitated payment and
you're paying for home care services, there's
only a few ways you can kind of manage within
that. On the home care side, you can either
try to provide less services or pay less for
those services, and both of those, frankly,
have proven a little bit difficult for the
plans.

The minimum wage was going up; hard to
drive down provider rates when the minimum
wage was going up, although certainly they
tried. Hard to sell your plan as the plan
that you can enroll in and get your services
cut, so from a competitive point of view they
didn't like to do that.

And so a number of plans chose a third
alternative, which was to find new people.
Even though they were banned from marketing,
they were able to use the for-profit fiscal
intermediaries, who had kind of emerged when
the MRT essentially deregulated the Consumer
Directed Program -- an explosion of these new
for-profit companies. They had no such
marketing ban. They could go out and hand
you a flyer that says, you know, Are you
taking care of your mom? You can get paid to
do that. Which certainly anybody who lives
in New York City has gotten one of those
flyers, heard an ad, seen it in the communities.

They were able to use those fiscal intermediaries to circumvent the ban on marketing and to grow their plans. We think that profit incentive for the plans has been one of the reasons for this extraordinary growth, and we think the MRT should take a hard look at that in terms of restructuring the system going forward.

CHAIRWOMAN KRUEGER: Thank you for moving through that so quickly.

Questions? Senator Gustavo Rivera.

SENATOR RIVERA: Thank you.

Thank you for that perspective, and I certainly agree with you that we need to look very closely at the cap as well as just redesign programs so that -- to create incentives so that people are taken care of, not that certain folks take advantage of it for monetary purposes.

But I did want to also ask, like I did the earlier folks who -- both Greater New York and HANYS. So for the record, has 1199
been reached out to be part of the MRT process?

MS. SCHAUER: No. No.

SENATOR RIVERA: Okay. It is -- do you share the concern that we might not have -- that the time frame is really, really tight to be able to come up with something?

MS. SCHAUER: So I would say a couple of things on that. I think, you know, as many people did when we heard about the MRT, I, you know, went back to my files of what happened in 2011. The time frame was not much longer, I will say. It was slightly longer, but it was also a couple of months.

SENATOR RIVERA: I would -- and the only reason I would interrupt you is -- you were here during the day, I'm sure -- I asked specifically -- the original MRT had a March 1st deadline to put something forward that then the Legislature could consider to put in the final budget proposal, and also could be part of the conversations that happened in the last couple of weeks related to putting the final budget proposal
together.

I asked the Department of Health as well as the acting Medicaid Director directly whether I could get a commitment from them that they would -- that this would follow such a timeline. I got no such commitment. And as I've made clear many, many times today, I don't trust that -- you know, trust, you've got to earn it, and I don't have it.

So if we are indeed put in a situation in which we are -- it's March 31st and then we have a proposal in front of us, you know, it's just -- I just want to know, particularly considering that you folks were certainly involved in the original back-and-forth putting the original MRT together, you were a very important part of that, like Greater New York and HANYS and a lot of other folks. Just -- is that -- I would argue that concern is warranted. Do you share it with me, or --

MS. SCHAUB: So I would say a couple of things. One is, yes, it's a tight timeline no matter how you cut it. If the
alternative is draconian across-the-board
cuts, you know, we're going to do as much as
we can in that timeline to come up with an
alternative. I certainly agree everybody has
to have a chance to look at what's being
considered in those proposals so that it can
truly be a stakeholder process, and we would
support that.

SENATOR RIVERA: Thank you so much.
Thank you, Madam Chair.

CHAIRWOMAN KRUEGER: Thank you.

Assembly.

CHAIRWOMAN WEINSTEIN: I just have a
quick question, looking through some of your
comments. When you talk about that -- the
enrollees needing a lower level of care, are
you inferring that maybe they don't belong --
that the level of care is so low that they
shouldn't be part of the program and that
there was some fraud involved in their being
signed up?

MS. SCHAUER: Not necessarily. I
mean, I think in a program this big you
certainly can argue that there's going to be
fraud somewhere. But mostly what we're arguing is that the plans have a financial incentive to find people who are -- who have lower needs of care and enroll them, because they're going to get a full capitated payment for that person and then they have to pay out much less. That's how they can help balance their books. I think if people saw a number of years ago there was this kind of scandal about the social adult day centers, which was a similar idea, that all of a sudden the plans were contracting with the social adult day centers for new enrollees, they would get the full capitated payment, and those in some cases were people who had very low levels.

So we think you've got to look at the incentives there -- you know, does it make sense to give a full capitated payment to a plan to manage somebody who needs a small amount of home care, or would it make sense just to pay for that home care directly in fee-for-service rather than pay the plan?

We're spending about $800 million in just plan administration in the managed long
term care plan -- not including care
management, but just the plan administration.
Does that really buy us enough to justify
that level of expense given where we are?

CHAIRWOMAN WEINSTEIN: I just know
from my own community, having a lot of people
who are either recent emigres, either older
Russian-speaking individuals or
Chinese-speaking individuals, that this
program has helped them.

So the question is, moving forward,
still allowing them to have their
language-specific -- have a caregiver that
can speak their language while not blowing up
the costs of Medicaid.

MS. SCHAUB: And we're certainly not
arguing against the CDPAP program. We did
support and the Legislature passed last year
a reform to raise standards for the fiscal
intermediaries. We think 700 mostly
for-profit fiscal intermediaries is crazy and
that it makes sense to return the
administration of that program to the
disability community, to the other
long-standing providers who can deliver those
services in a cost-effective way. It's not
about not delivering the services, but who
gets paid to deliver the services, both at
the plan level and at the intermediary level.

CHAIRWOMAN WEINSTEIN: Great. Thank
you.

CHAIRWOMAN KRUEGER: Thank you.

Senator Robert Jackson.

SENATOR JACKSON: Well, thank you.

Good afternoon. Hi. Thank you for coming
in.

Have you listened to all the testimony
this afternoon and this morning?

MS. SCHAUB: Almost all of it.

(Laughter.)

SENATOR JACKSON: That's good. That's
good. So I'm reading here where in your
statement you talk about that so many
hospitals have less than 15 days' cash on
hand and are dependent on extraordinary state
support to stay open. Like my colleague was
saying, hospitals in her area are on the
verge of closing.
So 1199, you may have heard me speak about 1199 at Isabella Geriatric Center, a thousand employees up there. And not only there, but Columbia Presbyterian and the New York State Nurses Association.

So am I wrong in saying that it doesn't seem to equal out as far as the cuts and maintaining the services? Am I right or wrong?

MS. SCHAUB: We are very, very concerned about what huge cuts of that magnitude would mean for the services and for the people who provide the services.

SENATOR JACKSON: So obviously, for me -- and 1199 doesn't want any layoffs, New York State Nurses Association doesn't want any layoffs, and other unions that represent -- and a hospital on the verge, they don't want to close. Because as my colleague said, there's big mileage between one hospital and another hospital.

So we have to think about how are we going to raise revenue. Is that correct? I haven't really heard people say that, but I'm
asking you, is that what we have to start
thinking about?

    MS. SCHAUB: You know, I know the
question was posed to the last group. You
know, we always say we don't represent any
wealthy people. And we do believe that
wealthy New Yorkers could pay more to help
make sure that we don't have to impose
draconian cuts on people who need care in our
state, from residents of nursing homes to
people who need their local emergency room to
stay open.

    SENATOR JACKSON: Well, I am hoping
that this new Medicaid -- what, MRT II, is
that what they're calling it? -- has some
good people on there that includes some
unions, some hospital people, besides the
individuals that -- you know, Dennis Rivera
represented 1199, and the hospital person has
the biggest hospital conglomerate in New York
State. So I would hope that they would know
that they don't want reductions. Reductions
mean employees that we represent will be laid
off, and that's not going to help them and
their families.

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

MS. SCHAUB: We absolutely support
that.

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

But if it happens in a planned way, to
make sure that the services are there for the
community, it also means we can retrain
people, put them in the settings that are
necessary, make sure that jobs are preserved
even if it's in a different context. And
that's what we'd like to see happen if we
need to reconfigure pieces of our healthcare
industry.

SENATOR JACKSON: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Anyone else? Thank you very much for
testifying today.

MS. SCHAUB: Thank you.

CHAIRWOMAN KRUEGER: Appreciate it.

The next up -- and I'm going to read a
few so that people can move down, because as
we get closer, you'll be closer. Next we
have Eric Linzer, Kathy Preston for New York
Health Plan Association. They'll be followed
by Community Health Care Association of
New York, Tiffany Portzer, followed by
Upstate New York Healthcare Coalition, Gary
Fitzgerald.

So again, if you move down closer, you
get right up front when you're called.

All right, and if there are two of you
speaking, know you're sharing five minutes.

MR. LINZER: Yes.

CHAIRWOMAN KRUEGER: So we always feel
bad for the second person, because usually
they get one minute. So just, you know, kick
him under the table, whatever's appropriate
for you. Did I just say that out loud? I
didn't say that out loud.

(Laughter.)

MR. LINZER: It's a hot mic, Senator, so --

(Laughter.)

MR. LINZER: So good afternoon,
Assemblymembers, members of the Senate. For
the record, my name is Eric Linzer. I'm the
president and CEO of the New York Health Plan
Association. With me today is Kathy Preston,
HPA's executive vice president.

We appreciate the opportunity to offer
our testimony today with regard to the
proposed FY '20-'21 Executive Budget. Just
for context, we represent 29 health plans in
New York that provide comprehensive
healthcare services to nearly 8 million
New Yorkers.

We recognize the fiscal challenge the
state currently faces, but we remain
concerned with the ongoing cuts in Medicaid, specifically to the health plans, which total roughly about $800 million in cuts the last three years. Our members have been consistent, reliable partners in the state's coverage expansion and delivery system reform efforts and have been responsible stewards of the state's funding around the Medicaid program.

To protect the coverage and services of the millions of New Yorkers who rely on our member health plans in the Medicaid space, we think closing the structural deficit should focus, among other things, on eliminating funding that doesn't meet the goals of either expanding access or reforming the delivery system, while rejecting any new taxes or other measures that will increase the cost of coverage for employers and consumers.

Earlier this month HPA outlined a comprehensive series of measures intended to decrease the structural deficit by roughly $900 million. Now, that's a start, we know
it doesn't get all the way. But these
proposals really focused on the goals of --
our funding mechanisms focused on reducing --
or increasing access to coverage, improving
quality or promoting delivery system reform.
Among the proposals we have were first
eliminating or substantially reducing certain
supplemental payment pools, which would
generate about $581 million in savings,
realigning the indigent care pool, which
would save about $138 million, and reforming
the health home program, which would save
about $150 million.

Now, we're not suggesting that this
money should go away, but it could be
reallocated into the Medicaid program to
ensure that the most vulnerable New Yorkers
continue to have access to the care that they
need.

In addition to that, our concern is
also that closing the gap should not result
in tax increases. New York currently
collects about $5 billion annually through
various taxes, surcharges and assessments on
health insurance through HCRA. I know this has been talked about earlier today. Our concern is any increase in those taxes only makes it that much more difficult for employers, consumers and unions to be able to access and pay for high-quality affordable coverage.

Now, there's been a lot talked about the MLTC program, and I know we'll go into a little more detail during Q&A. But we believe that our member MLTCs have improved the delivery of services, and they have successfully controlled costs for the state.

Before MRT I, just to give some perspective, personal-care spending in fee-for-service grew by about 40 percent from 2003 to 2010, with the number of recipients decreasing by about 15 percent. Today we've seen a relatively stable increase in the PMPM rate, but significant increases in enrollment.

And some of this really has to do more with, you know, some of the rules around what the state has implemented and in some
instances have failed to implement. And we think that there obviously needs to be more detail dug into this issue, particularly as it relates to fee-for-service.

Finally, with regard to some specific proposals in the Governor's budget, we're opposed to several sections in Part J. This provision spells out a number of statutory changes affecting health plan operations, and we think that these provisions have no direct financial impact on the State Budget. Therefore, we don't believe that broad policy proposals should be adopted in the budget, especially without any real data to support the necessity or impact, and would urge rejection of Part J, which from what we've been told was inadvertently -- many of those provisions were inadvertently included.

Finally, we're generally supportive of Part G, the Prescription Drug Pricing and Accountability Board. And I know there's been some conversation about the challenge around prescription drug costs. Our concern with it is while we appreciate the focus on
rising prescription drug prices, which are a major challenge for both the commercial market and the Medicaid space, our concern is that the hundred percent threshold, the doubling of a price, we think is too high a bar and really needs to be lowered.

The state should not wait until a price is doubled to take a look at whether or not those price increases are justified, nor should patients or consumers have to wait until that level is hit. And we think that manufacturers may in fact try and keep those prices just below a doubling, which would create certainly ongoing challenges around keeping prescription drug costs controlled.

With that, we appreciate the opportunity to testify and we'd be happy to answer any questions you might have.

CHAIRWOMAN KRUEGER: Thank you. All right, you got it in five minutes.

Anyone else? Gustavo Rivera.

SENATOR RIVERA: Good afternoon, folks. Thank you for your patience.

A couple of things. Just because I'm
asking everybody on the record, have you been
approached by the administration to be part
of the MRT process?

MR. LINZER: No.

SENATOR RIVERA: Okay. And you have
on page 4 of your testimony -- and as you
were doing -- you know, quickly going through
part of it, you talked about in the area of
taxes, the sentence here is "We're especially
cconcerned by recent news reports the MRT will
consider raising taxes on health insurance as
a way to close the gap." So obviously your
position on that is clear.

Are you also opposed to a larger
conversation of generating revenue from
wealthier individuals?

MR. LINZER: I think the conversation
at the MRT -- the MRT shouldn't be charged
with trying to make decisions around tax
policy. I mean, that's, you know, something
that should be separate and apart from MRT.

MRT's focus should be on looking at
the structural challenges within Medicaid and
how do we get those costs under control.
SENATOR RIVERA: You were here when Helen Schaub from 1199 testified just a little bit ago, and I'm sure that you heard some of the concerns that she has on behalf of her union related to what they feel are inducements, if you will, in the current structures that have plans take advantage -- the words that they used were that they are financially incentivized, right, that there's financial incentive to just go and get more folks and not necessarily provide the services.

Do you share these concerns?

MS. PRESTON: No. The idea that managed long term care plans are responsible for Medicaid overspending is a red herring. There's no financial incentive for plans to enroll low utilizers. The rates are risk-adjusted, so if you have a plan that has gone and enrolled a large number of folks who are low utilizers, their rate gets reduced through a risk adjuster. That's how the rates work, in order to reflect the fact that some plans do have more folks who are higher
SENATOR RIVERA: Okay. And do you have a position, an official position on the cap and whether it should be revisited or maintained?

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

SENATOR RIVERA: Last, actually, very, very last question, do you also share my concern and the concern of some of my colleagues that the timeline is exceedingly small and short to be able to tackle such an enormous problem?
MR. LINZER: And the short answer is yes. I mean, I think as you've heard from other folks, it's an aggressive time frame. Plans were not -- you know, the association was not part of the first MRT. But to that end, we think it's going to be vitally important that health plans and other purchasers be part of that conversation and not have it particularly provider-centric, as it was the last go-round.

SENATOR RIVERA: Thank you so much.

Thank you, Madam Chair.

CHAIRWOMAN KRUEGER: Thank you.

Assemblymember Byrne.

ASSEMBLYMAN BYRNE: Yes, thank you again for being here and being patient.

A similar question that I had for the hospitals earlier. We've -- you know, you've been speaking about the need for transparency and balance for the Medicaid Redesign Team II, MRT II. And we already know who the two cochairs are, and they have background and experience and affiliations, and we have a lot of other stakeholders who are going to be
affected by this.

First of all, would you see the health
plans being a participant of that? And who
else -- what other advocates and groups
should be a part of that process?

MR. LINZER: So as the largest
statewide and most diverse health plan trade
association in New York, HPA would certainly
like to be part of that. And there should be
substantial plan representation, because
Medicaid has relied heavily on our industry
to -- you know, to -- around coverage
expansion and delivery system reform.

In addition to that, there should be a
broad and diverse group of individuals who I
think certainly -- who can provide
perspective. Among them should be the
state's actuary, Deloitte. Because as you
get into conversations about either potential
cuts or reductions, there needs to be a
meaningful conversation about actuarial
soundness around rates.

Second, there probably needs to be
some employer and purchaser participation on
there. Because if there's going to be a conversation around taxes or assessments, well, then there needs to be a conversation of who pays for those.

And then finally, you know, it might make sense to have some independent entities who have been looking at this issue, whether it be Citizens Budget or the Empire Center or others who have been paying close attention to this and can provide some independent perspective on the challenges that the state faces.

ASSEMBLYMAN BYRNE: Thank you. I appreciate your remarks. And I would actually agree with those recommendations. And I think having a balanced, transparent process -- we're already in a rushed timeline, but having all stakeholders present and participate I think is absolutely crucial.

Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Senator Diane Savino.

SENATOR SAVINO: Thank you,
Senator Krueger.

Good afternoon. Eric, you didn't read your testimony, but I just want to point out on page 2 is a pretty startling number that you -- you talked about the growth of the MLTC programs. I've spoken about it a few times today, the growth in long-term care.

In your testimony you state that when the CDPAP program was instituted in 2014, the state spent $129.5 million on it. And as of now, projected for FY 2021, it's 1.8 billion.

How did we get from $129 million to 1.8 billion?

MS. PRESTON: Right. Well, we've been asking for those numbers for a while, actually. I'm not sure we have a full picture of what exactly has happened in CDPAP.

So looking at some of just our MLTC numbers, it grew from 83 million in 2014 to 1.9 billion. That's an increase of over 2,000 percent. I've never seen anything grow at 2,000 percent. It was a policy of the Health Department to expand the
Consumer-Directed Program. It's an important tool to help folks who are eligible for it remain in the community and independent.

SENATOR SAVINO: Right. We -- none of us disagree with that.

MS. PRESTON: Right. But we have -- we raised -- the plans raised the flag on this a couple of years ago and tried to have some serious conversations about it.

Last year's budget included a couple of provisions; one was to limit the number of FIs in the program, and the other was, in keeping with that, to change the reimbursement to the FIs. The way they are reimbursed drives additional hours, because they get paid based on hours. So we suggested, it was actually a plan suggestion, to pay them that flat per-member per-month rate, because then you take out that incentive.

But there needs to be more conversation about how this happened over such a short period of time.

SENATOR SAVINO: It's extraordinary.
In five years, it's gone up -- I can't even figure out the percentage. Somebody smarter out there than me can figure it out. But it's an extraordinary amount of money in a relatively short period of time. And it just defies logic that no one's really drilling down into this to figure out how we got where we are, because that there alone is more than half of the budget deficit -- or the Medicaid deficit.

MS. PRESTON: Right.

SENATOR SAVINO: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Assembly.

CHAIRWOMAN WEINSTEIN: Assemblyman Cahill.

ASSEMBLYMAN CAHILL: Hi. Thanks, folks, and thanks for being here. Just a couple of quick questions, first about EI. The Governor has proposed that you do pay-and-pursue when it comes to Early Intervention. Can you give me your thoughts on that proposal?

MR. LINZER: So I think we understand
the state's desire to try and reduce some of
the costs on the municipalities. I heard the
classification earlier today, and some of your
comments, Mr. Chairman.

I think our concern becomes when we
start, similar to -- and this shouldn't be
any surprise -- shifting additional or other
state or county costs onto the commercial
market, you know, only is going to lead to
higher health insurance premiums. I think to
your point earlier, about this has been an
ongoing issue that you've looked at and have
raised in the past, and maybe it's high time
to really pull some of the folks involved in
this together to have a meaningful
conversation separate and apart from the
budget dialogue, to see what the issues are
and how best to address this.

ASSEMBLYMAN CAHILL: So you wouldn't
be opposed to doing something other than
finding out who does the pursuit for payment?

MR. LINZER: I think we'd want to have
a -- you know, I think -- I'm not suggesting
that we may support other approaches, but I
think, you know, this one in particular is,
you know, merely just shifting costs from one
entity to another and doesn't get at what the
underlying drivers are here.

ASSEMBLYMAN CAHILL: Am I hearing you
say that you're opposed to the Governor's
pay-and-pursue?

MR. LINZER: Oh, yeah. Yes.

ASSEMBLYMAN CAHILL: I just want to
make sure --

MR. LINZER: Oh, yes. Yup.

ASSEMBLYMAN CAHILL: I didn't know
that -- I went through your written testimony
but I didn't see it there.

So the other question that's coming up
and it's kind of lingering out there is what
happens to insurance plans if a decision is
made that somehow or another a good way to
fill the gap without impacting beneficiaries,
as they were called -- they're actually
called recipients, under the law -- for
Medicaid, and without going after our local
governments to pay more. There's only a
couple of other places to go, and guess what?
You're one of them.

What if that were to come to pass?

What impact would that have on ratepayers in New York State for health insurance?

MR. LINZER: Well, we are taking a look at what the impact would be on premiums. But depending upon what the number is, or regardless of what the number is, any amount of the 2.5 billion shifted onto the private market, either through increased HCRA taxes or other taxes, is going to lead to higher health insurance premiums.

And I think the challenge here is that to ask the private commercial market, employers and consumers and unions, to have to fill the gap in the state -- with the state unable to manage its Medicaid costs, just seems to be unfair to those individuals.

That said, part of the reason why we outlined what we did a couple of weeks ago, around ways to close the gap, is at a time when you're facing a $2.5 billion deficit, or whatever the number may be -- you know, resources are finite, they're limited, and we
need to make sure that we're making the best
use of those dollars. So as we outlined,
there's a number of supplemental payment
pools that have been around for years, and in
some instances decades, that sort of begs the
question, why are they necessary?

There was a conversation earlier today
about the medical malpractice pool. I think
if the issue here is, you know, if medical
malpractice is a challenge regardless of why
the pool is there, is it meeting the goals of
what we should be doing in Medicaid, which is
making sure people have coverage, reforming
the delivery system, and improving quality.

So there's a number of pools that
we've outlined -- you know, medical
malpractice is one, recruitment and
retention. There's dollars there. We're not
suggesting taking away --

ASSEMBLYMAN CAHILL: We're down to the
last minute, and I swore I wasn't going to
take the whole time. But -- so the answer to
the question is you think there are other
places to go than doing some sort of
assessment against insurance companies to pay

for it.

MR. LINZER: Oh, absolutely.

ASSEMBLYMAN CAHILL: So my last

question to you is there has been some talk,

not very formal, not very deep, about

instituting a state individual mandate. Does

the group have an opinion on that?

MR. LINZER: Yeah, we'd be supportive

of an individual mandate. I think --

ASSEMBLYMAN CAHILL: That's good, we
can stop there. That's good. Thanks. Bye.

(Laughter.)

CHAIRWOMAN WEINSTEIN: Senate?

CHAIRWOMAN KRUEGER: Robert Jackson.

SENATOR JACKSON: Thank you for coming

in. Appreciate you. So I was listening
to -- I thought I heard you say, and correct
me if I'm wrong, that -- basically that you
didn't see taxes would -- increasing taxes
would help this situation.

MR. LINZER: I think what I said was
two things. One, taxes would -- and

particularly in the health insurance space,
is going to exacerbate the challenge of
affordability for employers and consumers.

SENATOR JACKSON: Okay, hold it right
there. You said impact affordability. But
taxes -- if we talk about revenue, asking
those that are millionaires or above, it's
not going to impact 99 percent of the people
that have health insurance. You know what
I'm saying. Do you agree with that or
disagree?

MR. LINZER: Senator, I think we're --
you know, the context in which I'm discussing
is around HCRA taxes. And the fact is we've
got -- we -- you know, there are 5 -- and
this was brought up a number of times today,
but $5 billion in taxes imposed on health
insurance only exacerbates the challenge that
employers and consumers and unions and others
face in paying for health insurance,
regardless of what your income level is.

So on the private marketplace it
does -- you know, it does create real
challenges for individuals who are trying to
pay the monthly premium.
SENATOR JACKSON: But -- but -- okay, so if -- basically, I guess if I'm looking at you, you're opposed to raising revenue to deal with this particular matter. That's what I'm seeing. No matter what you're saying, that's what you -- the vibes you've given off to me. And if that's the case, then we're going to either have to shrink what currently exists in order to fit within that monetary pot that we have, or do reductions and shrinkage. And that is going to be devastating on the people that we represent.

MR. LINZER: But Senator, as I mentioned, there's a number of supplemental payment pools that, you know, ought to be looked at and determine whether or not they're really necessary. Now, I'm not suggesting we take all that money away. That money certainly could be reallocated within the Medicaid program to shrink the gap and minimize some of the challenges.

The Indigent Care Pool is, you know, certainly an example where, you know, you've
got certain hospitals that, you know, may see
a small number of low-income uninsured
individuals but still -- you know, and have
substantial margins and don't really need the
funding. As opposed to other institutions
that, you know, are the backbone of the
indigent care system to be -- and aren't
going sort of really, you know, sufficient
funding.

So I think -- you know, I emphasize
that when you look at some of these pools,
you know, at a time when you're dealing with,
you know, a significant budget deficit, some
of the focus needs to be on reforming how we
spend those dollars.

SENATOR JACKSON: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Thanks for your testimony today.

Our next up is Community Health Care
Association of New York State, come on up.
And then for people getting closer, we have
Upstate New York Healthcare Association, then
the New York State Association of County
Health Officials.
MS. PORTZER: Hello.

CHAIRWOMAN KRUEGER: Hello.

MS. PORTZER: I was going to say --

this morning I wondered would I say good
morning or good afternoon, and now I think
it's good evening, actually.

(Laughter, overtalk.)

MS. PORTZER: All right, I'll go with
good afternoon. And thank you for the
opportunity to provide testimony on the
Governor's budget proposal. I'm Tiffany
Portzer, vice president of communications at
the Community Health Care Association of
New York State, better known as CHCANYS. Our
president and CEO, Rose Duhan, apologizes for
not being here today; she had a prior
out-of-state commitment.

A little bit about us. CHCANYS is
the voice of New York's 70 community health
centers, CHCs for short, which provide
comprehensive primary care services at more
than 800 sites statewide to 2.4 million
New Yorkers, regardless of their immigration
status, insurance coverage, or ability to
pay. That's one in eight New Yorkers we provide care for.

You have our written testimony, but I want to hit a few key points in my oral testimony today.

First, PCMH. CHCANYS respectfully requests that the Legislature ensure that the PCMH program funding is protected at 2019 levels at a minimum -- New York State has identified the patient-centered medical home model as the gold standard of comprehensive primary care -- and, through DSRIP, to incentivize providers to participate in the program. Ninety-three percent of New York health centers are PCMH-certified and CHCANYS estimates that CHCs received more than $56 million in PCMH incentive payments in 2019.

Studies have found that individuals who saw primary care physicians at PCMH-certified sites had fewer specialty visits and 14 percent lower per-patient costs when compared to individuals seen at other primary care providers. Nationally,
PCMH-enrolled individuals are less likely to receive care in an emergency department when compared to non-PCMH-enrolled individuals.

Funding for the PCMH program is a crucial investment in high-quality, comprehensive primary care practices. Any reduction to PCMH funding will directly impact health centers' ability to continue to provide coordinated care management services and to prepare for and engage in value-based payment arrangements.

For the past two years, thanks to your efforts, PCMH funding has remained stable, providing critical support for community health centers and other primary care providers. We ask that you continue your support of this important program and support level funding for PCMH.

Second, CHCANYs requests that the Legislature dedicate 40 percent of future DSRIP funds directly to community-based providers, including community health centers, behavioral health providers, home care, and hospice providers. In November
2019, the state submitted a proposal to CMS requesting $8 billion to implement a new DSRIP program, DSRIP 2.0, which would run from April 2020 to March 2024. CHCANYS applauds the state's work in the first round of DSRIP to reduce costs, improve patient outcomes, and decrease unnecessary inpatient and emergency room utilization.

Community health centers were leads or key partners in achieving many of the benchmarks. However, the first round of DSRIP had no specific requirements about how funds flow to partners in the PPS networks. And as a result, the amounts received by CHCs varied.

For New York State to experience a real transformation of the healthcare delivery system, and sustain the gains thus far achieved through DSRIP, there must be a significant direct investment in community-based care. CHCs' delivery of advanced comprehensive primary care has led directly to the successful achievement of DSRIP's primary goals, reducing avoidable
hospitalizations and inappropriate presentations at emergency rooms.

CHCANYS thanks the Legislature for your ongoing support of community-based providers and requests that you mandate that at least 40 percent of any future DSRIP funds be allocated directly to community-based providers, including CHCs.

Third, CHCANYS urges the Legislature to maintain the diagnostic and treatment centers safety-net pool at current funding levels. The Governor and Legislature have historically supported funding for the safety-net pool to help cover CHCs' cost of caring for the uninsured, which makes up 16 percent of patients. As in prior years, this year's Executive Budget includes $54.4 million in state funding, which would draw down an equal federal match. The funding partially reimburses CHCs for the cost of caring for the uninsured, the rate of which is three times higher at CHCs than in the general New York State population. However, at some health centers -- get
more than half of the patients are uninsured.

The funding is particularly important in light of the recent Supreme Court decision to allow the public charge rule to take effect nationwide. Although the rule only applies to a small percentage of legal immigrants, the chilling effect is expected to be widespread. Health centers have already reported patients choosing to disenroll in Medicaid for fear of immigration actions. The safety net funding is a critical resource to help cover the cost of caring for the uninsured, which we anticipate could rise due to ongoing fears in the immigration community.

Finally, I wanted to quickly address the Governor's proposal to reconvene the MRT, which is something we've obviously heard a lot about today. It is imperative that MRT include representation from community-based providers and Medicaid consumers, including community health centers and our representatives. We urge the Legislature to
ensure that the MRT and budget process is transparent and accounts for the full spectrum of New York's healthcare system.

I thank you for your time today, and for giving us the opportunity to testify, and I'm happy to answer any of your questions.

CHAIRWOMAN KRUEGER: Thank you.

SENATOR JACKSON: Whoop! (Applauding.)

MS. PORTZER: And I made it!

CHAIRWOMAN KRUEGER: Gustavo Rivera.

SENATOR RIVERA: (imitating auctioneer) Sold!

(Laughter.)

MS. PORTZER: I was listening to you earlier, and I was like, we're in a run for each other's money here.

SENATOR RIVERA: That is fantastic.

First of all, I thank you for being the first -- the first -- and I know we have a lot of folks to go, but the first organization or representative of an organization to mention the public charge. I had the opportunity to talk very briefly --

MS. PORTZER: I'm having a little bit
of a hard time hearing you, sorry.

SENATOR RIVERA: I am thankful that you referred to the public charge rule and the impact that it would potentially -- that it will have on the state.

MS. PORTZER: It's already having.

SENATOR RIVERA: Right, we're just trying to figure out how deep that impact is going to go. It was -- I had a brief part of the conversation that I had with the Department of Health and the Medicaid Director this morning when I mentioned it right at the end of their testimony.

But it's obviously something that we're going to have to deal with, because as you said, we're -- it's impacting us now.

And you also -- I was surprised that you hadn't mentioned anything about the MRT. You did towards the end, and so as I did with everybody else -- I think I know what the answer is -- but has your organization been officially asked or contacted by the administration to be part of the MRT process?

MS. PORTZER: (Shaking head.)
SENATOR RIVERA: Could you say it, please?

MS. PORTZER: No.

SENATOR RIVERA: There you go.

because we need it for the record.

So the -- and would you -- do you have a position on the cap, since there has been a conversation about it?

MS. PORTZER: Not speci -- we just want to be part of any conversations that are happening.

SENATOR RIVERA: Gotcha. So does that mean that you're supportive of keeping the cap in place or --

MS. PORTZER: It's not a conversation that I've had with my colleagues at this point, so it's not really something I can answer right now. But any ongoing conversations, we want to be part of.

Community health centers I think sometimes get left out of the conversation --

SENATOR RIVERA: Yes, ma'am.

MS. PORTZER: We want a seat at the table, us and consumers of Medicaid and
consumers of healthcare.

SENATOR RIVERA: Understood and agreed.

And the -- related to -- and I figure that you have -- I'm also asking folks about the timing and whether the timing that we're dealing with is realistic. So just do you have an opinion on that from the perspective of the community health centers?

MS. PORTZER: Anything is realistic. Again, all I'll say is we want a seat at the table as the conversations progress.

SENATOR RIVERA: Thank you so much.

MS. PORTZER: Thank you.

SENATOR RIVERA: Thank you, Madam Chair.

CHAIRWOMAN KRUEGER: Thank you. Assembly? Any other Senators? Then thank you very much for being here today.

MS. PORTZER: Thank you very much.

CHAIRWOMAN KRUEGER: So our next testifier is Upstate New York Healthcare Coalition, Gary Fitzgerald.

Then for people who are watching to
get ready to be on deck, we'll then next have
the New York State Association of County
Health Officials -- three people in five
minutes, fight it out in the hall quick --
then Feeding New York State.

Good evening.

MR. FITZGERALD: Good evening.

CHAIRWOMAN KRUEGER: Afternoon. Still
afternoon.

MR. FITZGERALD: Is this on? Yes, it
is.

Thank you, Chairs Krueger and
Weinstein, Gottfried and Rivera, and the rest
of the legislators. Thank you very much for
the opportunity to listen and to speak
briefly. I'm going to sum up my summary, so
I won't take long.

I'm here really to talk about the
Upstate Healthcare Coalition. It's a group
of hospitals and healthcare systems from
Albany down to Columbia County and over to
Buffalo. We got together last year to make
sure that the needs and the specific issues
related to upstate healthcare providers are
made apparent to you. And I will --

Senator Ritchie teed me up for my remarks
about the upstate hospitals earlier today.

The upstate hospitals face different
issues than downstate hospitals. And it's
not bad or good, it's just different. We
have a different payer mix, we have high
Medicare, lower Medicaid, older patients,
sicker patients. We have geography problems
that you talked about. And we have a huge
workforce shortage across upstate New York.
Not just in physicians, but in every worker
area in the healthcare industry, we have
shortages. So I'd like to comment about
that.

As far as our -- we have 34 -- 35,
excuse me, communities in upstate New York
that have one hospital in that community.
Those are called sole community hospitals or
critical access hospitals. That means if
that hospital goes down or becomes converted
into an emergency room, like has happened in
a number of our communities, those hospitals
also employ the doctors in that community, so
those doctors will probably leave the community if that hospital closes and is converted into something less than a hospital.

And we're not asking for all the hospitals in upstate New York to have all the technology and all the services. As you mentioned, Senator, we have downsized over the years; we just need the basic services, and I think the citizens of upstate New York deserve those basic healthcare services in their communities.

As far as funding goes, 85 percent of the hospitals in upstate New York lost money in 2017. Those are the last numbers that we have. Eighty-five percent had a negative margin. The average margin in upstate hospitals is minus 4.3 percent. So to the comments earlier, I think it was Assemblyman Cahill and others, there's just no way that you can absorb additional cuts to the magnitude of 2.5 billion, or whatever the number ends up being, without seeing services eliminated and some hospitals closing.
And as I said, the trend is a hospital one day, an emergency room the next day. And that's just not fair for some of our communities.

And if you want to talk about business development, what business in their right mind would ever come to an upstate community that has just closed its hospital and it's very difficult to get a doctor's appointment in that community?

That's why we'd urge you to consider, and we've made this clear to the Governor and his staff, that the hundreds of millions of dollars in economic development that the Governor has put into upstate communities, it's a great thing -- but we've tried to get them to just take a little bit of that money and use it for workforce development in upstate communities -- healthcare workforce development. Whether it's loans, loan forgiveness, continue to expand those programs, training, recruitment, retention -- we're doing all that through our association, but we cannot break through the economic
development funding sources to explain that without healthcare systems in upstate New York, you will not get economic development in those communities.

We do have, as I said, a workforce shortage. We have 2,000 vacancies from Buffalo to Albany in the hospital inpatient setting of RNs. So when we talk about nurse staffing ratios, which was mentioned, again, earlier today, it's very hard for us to understand how we could fill those vacancies with the mandated staffing ratio bill that's being discussed. We don't have the money and we don't have the nurses. So unless there's some major issues changing in education, training, and the recruitment and retention of those RNs, there's no way that that bill would be enforceable in upstate New York. Or else you just close the facilities and their services.

I'll leave you with this quote -- or this statistic that we found a couple of weeks ago in a New York Times article: Over 100 rural hospitals have closed across the
country over the last 10 years, including, as I said, several in upstate New York. We don't want to see this trend continue. And this Medicaid cut coming is -- obviously would continue that trend in upstate New York. And for all the reasons that I've said earlier -- you lose those hospitals, you lose those doctors, in some cases you lose the nursing home that's attached to that hospital. And that would be devastating for these upstate communities.

So I will work with you, we will work with the MRT. Quite frankly, before you ask the question, Senator, I have not been asked to serve on the MRT by the administration.

(Laughter.)

MR. FITZGERALD: But we will do whatever we can do in the next 60 days to make it happen.

One thing that I will point out, in 2017 we passed -- you passed. We passed? -- Chapter 419 of the Laws of 2017, which created the Rural Health Council. It has members from each house and the Governor's
appointments. That was put together with our
staff, trying to figure out ways to get a
New York State rural health plan in place.
No appointments have been made by the
Governor. No meetings of the Rural Health
Council since 2017 have been -- have taken
place.

So good legislation, thank you for
passing it in both houses, he signed it, but
we still don't have a Rural Health Council
put in place. Now would be a great time for
that, quite frankly. And it could meet on a
regular basis for more than just 60 days so
we could figure out some of the problems that
I've brought up today.

So with that, I'm done.

CHAIRWOMAN KRUEGER: Thank you.

Any questions from the Senate? Pat
Ritchie. Oh, I'm sorry. Senator Rivera, the
Health chair.

SENATOR RIVERA: You already answered
my first one, thank you for that.

Do you have an official position on
the cap?
MR. FITZGERALD: Yes, the cap needs to be looked at, reexamined. It needs -- probably needs to be raised, quite frankly. It's 10 years old, so it needs to be looked at.

SENIOR RIVERA: All right. Thank you, sir.

CHAIRWOMAN KRUEGER: Assembly, any?

(Off the record.)

CHAIRWOMAN KRUEGER: Senator Pat Ritchie.

SENIOR RITCHIE: I just want to say thank you for partnering with me in the past to do the take-a-look tour. That was something I think was beneficial. Hopefully we can do that again.

You answered most of my questions during your five minutes. I would just like to ask, as far as -- we started off with a doctor shortage and then a shortage in nurses. The nursing shortage seems to be getting even worse pretty much by the day. Do you have any idea with regards to the doctor shortage, is that maintaining, or both
of them increasing exponentially?

MR. FITZGERALD: Well, we see them increasing, quite frankly -- aging out of the workforce, with the nurses and doctors as well, burnout, all the issues we talked about.

And we just actually -- not signed it yet, but we're in the process of dealing with the Empire State College to connect their online training for nurses and CNAs and others with our hospitals and the vacancies that we have. So we're doing what we can to try to increase training and education for CNAs and nurses. That's really a main problem.

Some of the problems in the rural areas, you can't get enough nurses to do the training. They're either retired or they don't want to be part of it or it's not -- we're not paying them enough to do the training.

So we're working -- it's -- the problem is getting worse, but we're trying to experiment with different ways to make it
better. We even just recently signed an agreement with St. George's University in Grenada to bring some of their medical students into upstate New York so that hopefully they train here and they stay here. And so we're pulling out all the stops.

We'd like to do another round of tours if we can get some funding for that, Senator. It's exposing downstate students and residents to the upstate New York healthcare system. And when they get here, they can't believe we actually have technology and running water sometimes.

(Laughter.)

SENIOR RITCHIE: I'd just like to finish by saying I appreciate you talking about how dire the situation is. I know earlier I brought up how many times I've gotten calls from hospitals and nursing homes in my last nine years, and it's pretty much on a weekly basis. So we really are in a critical situation.

MR. FITZGERALD: Well, and I know we have a number of hospitals today that are
under that 15-day cash-on-hand number, and
they're in upstate New York. So that's a
serious sign.

CHAIRWOMAN KRUEGER: Thank you very
much. Appreciate you being here.

Oh, stay where you are. Senator
Seward.

SENATOR SEWARD: Thank you.

Gary, I just wanted to say -- there is
a question coming, but I just wanted to say
that I've appreciated your work over the
years and your organization and your staff
and member hospitals for highlighting the
needs of our upstate hospitals, particularly
in the rural parts of our state. And I know
you represent a mix in terms of some of the
larger cities upstate.

But there are special challenges in
terms of operating a hospital in the more
rural parts of our state, as Senator Ritchie
has pointed out. And we really do need to
recognize that, because if a hospital closes
in a rural community, not only is it
devastating for that community, there may be,
you know, 40, 30, 50 miles to the next available hospital.

MR. FITZGERALD: That's right.

SENATOR SEWARD: I mean, so you have the distances -- very bad for the people of that region.

My question is, I know you got a Happy New Year good wishes with that 1 percent --

MR. FITZGERALD: New Year's Eve.

SENATOR SEWARD: -- New Year's Eve, announced for the hospitals and health systems, an across-the-board 1 percent cut in Medicaid.

MR. FITZGERALD: Yes.

SENATOR SEWARD: Now, that totals $500 million annually?

MR. FITZGERALD: When you annualize it out, yes, with the federal share, yes.

SENATOR SEWARD: Would it be your position, shall we say, in terms of actual cuts in Medicaid payments, you've already contributed?

MR. FITZGERALD: We've already given at the New Year's Eve party. And that should
be included. Remember, that -- the
Governor's budget doesn't roll that through
2020-2021. So yes, we've already given. And
it -- it -- continuing to cut Medicaid, as I
said, in upstate New York it only pays
69 cents on the dollar now, so you just
continue to --

SENATOR SEWARD: Right. Well, I think
that's an important point to raise as they
look at another $2.5 billion in savings:
Looking to further cuts in some of these
struggling hospitals and other health systems
is not the answer.

Thank you.

MR. FITZGERALD: Thank you.

CHAIRWOMAN KRUEGER: Thank you. Now
we're going to let you off. Thank you very
much, Gary.

Next up, New York State Association of
County Health Officials. I see perhaps two,
not three.

Hi. Evening.

DR. GUPTA: Good afternoon, Senator
Rivera, Assemblymember Gottfried, Senator
Krueger, Assemblymember Weinstein, and distinguished committee members. Thank you for this opportunity to provide testimony on the 2020-2021 Executive Budget.

My name is Indu Gupta. I am commissioner of health in Onondaga County, in central New York, and I'm here to represent the New York State Association of County Health Officials, known as NYSACHO, as a member of the board of directors, along with NYSACHO's executive director, Sarah Ravenhall.

NYSACHO understands the imperative of closing the state's budget gap. We appreciate that the proposed budget did not contain any cuts in critical public health funds. However, we are concerned that the proposal did not include a long-requested increase in Article VI funding which supports the core public health local health departments do every day.

Public health departments are dedicated to improve and protect health of people and their communities where they are
born, live, learn, work and play. You may have heard of the phrase "Our zip code is a better predictor of our health than our genetic code," because the factors we call social determinants of health impact 80 percent of the health outcomes of a person, and cumulatively health of the communities.

So what do local health departments do? We continue to monitor and mitigate the reemergence of all communicable diseases such as vaccine-preventable hepatitis A, measles, virus infections, to the very recent unfolding of the novel coronavirus infection in the United States imported from China, to any new public health threat on the horizon within the country, such as vaping.

At the same time, we remain dedicated to much-needed work to reduce lead exposure to protect the health of children, home visits to check on moms, babies and dads, and provide support services during early childhood by the Early Intervention program.

We continue to work to keep our
environment safe through restaurant inspections, ensuring water safety, performing camp inspections, and the list is long. We continue to work quietly in the background with only one laser-focused goal: Keeping our communities safe and healthy.

Imagine the impact of lack of any of these services in our respective communities. Can we as a society afford it? The answer certainly is no.

In our comprehensive written testimony submitted for your review, we respectfully ask and urge you and your staff to please carefully consider the priorities and concerns articulated within it. Due to the time constraint, I'll bring your attention to three specific areas.

One, NYSACHO continues to strongly oppose adult-use cannabis, based on science and experiences in other states, which has shown that it adversely impacts health, both at an individual and societal level. However, if the state proceeds with the program, we ask that local public health
officials, who are the chief health
strategists of the communities, have a
crrecte role in steering cannabis policies
and should be provided additional resources
for surveillance and education.

Number two, to ensure effective
implementation of the important work to
reduce childhood exposure to lead, we urge
that the state allocate $46 million to cover
the full cost of the expanded mandate.

Number three is we also ask that the
local health departments play a key role in
the state's Medicaid redesign initiative with
MRT II or DSRIP 2.0, because local health
Departments are the bridge between healthcare
and the community.

Thank you for your continued support
of public health by supporting the work of
local health departments. We are happy to
address any questions you may have.

CHAIRWOMAN KRUEGER: Thank you.

Senators?

SENATOR RIVERA: Do you, as an
organi -- first of all, thank you for being
here and thank you for your patience. Has
your organization been approached by the
administration to participate in the MRT
process?

MS. RAVENHALL: We submitted formal
correspondence to the Governor's office
requesting a seat at the table because we
think it's imperative and critical local
health departments play a role in MRT II/
DSRIP reform initiatives.

And to answer your question, the
answer is no, we have not received a
subsequent formal invitation or designated
role in that initiative.

SENATOR RIVERA: What is the position
of your organization on the Medicaid cap?

MS. RAVENHALL: We don't have a formal
position on the Medicaid cap. Anything that
impacts county government impacts local
health departments, and so it's something we
work closely with NYSAC on and keep an eye
on. It's certainly something that we are
careful about.

SENATOR RIVERA: And I'm sure that
you're also concerned about the potential reorganization of the local share that's being spoken about, the 2 percent, 3 percent thing. Right?

In the organization of county health officials, I figure -- how many -- do you have every county that's not the City of New York?

MS. RAVENHALL: We represent all jurisdictions, so we include New York City in that.

SENATOR RIVERA: Including New York City.

MS. RAVENHALL: Yes. We represent New York City.

SENATOR RIVERA: Gotcha. So there's -- so you have representation of the 62 counties in your organization.

MS. RAVENHALL: Yes.

SENATOR RIVERA: And so then you're probably -- well, besides obviously the administration, you would probably be the best to provide data that actually comes from the analysis within those counties about
whether they are -- whether they would be
impacted by the proposal that we have in
front of us. I'm sure that you have heard
from them. I know that I've only heard from
a few. I mean, the City of New York has its
estimate, which is enormous, but obviously it
is an enormous locality. But I've heard from
Westchester County and -- I know one of my
colleagues heard from an upstate county, and
I can't recall the number -- or I can't
recall the county itself. But I figure
you've heard from most counties.

Do you have a sense -- even though the
administration could not tell us this morning
when we asked them directly, and we have
asked them before, Can you provide us
information on what counties would be
impacted by this proposal? And they couldn't
tell us. I figure you probably have a better
idea.

MS. RAVENHALL: I don't have the data
on hand, but I'd be happy to get it to you
after this hearing.

SENATOR RIVERA: Yes.
MS. RAVENHALL: And then, you know, something else that we're concerned about is the Article VI funding, and specifically the cut that was implemented last year to the New York City Department of Health and Mental Hygiene.

Any threatened cuts to Article VI concerns, you know, all of our membership because it's kind of the bread and butter of local health departments and how we're funded. A lot of times residents will work in Manhattan and live in Westchester, work in Queens and live in Nassau County. And so public health impacts everybody and the work that the New York City Department of Health and Mental Hygiene does is really critical in that Article VI.

SENATOR RIVERA: So I would appreciate -- we would appreciate, as a Legislature, those numbers, because since apparently the administration doesn't want to give it to us, then we could at least -- and I know that some of my colleagues have already heard from particular counties that
have approached them. But it is likely that
you have a better network, right, because
they all -- you have -- you probably have a
little phone tree that --

MS. RAVENHALL: Senator, I'd be happy
to get back to you after this hearing,
absolutely.

SENATOR RIVERA: And -- but even
though you might not have the data in front
of you, the conversations that you've had
with county health officials that have
reached out to you -- because I'm sure many
of them have -- have there been any of them
that say, like, we're fine, we're going to be
fine?

MS. RAVENHALL: No, it will impact
everyone, all of our counties.

SENATOR RIVERA: Right. Thank you so
much for being here.

Thank you, Madam Chair.

CHAIRWOMAN KRUEGER: Assembly?

CHAIRWOMAN WEINSTEIN: No, we're all
through.

CHAIRWOMAN KRUEGER: Senator Jackson,
did you have a question?

SENATOR JACKSON: Thank you. I'm just curious, I mean, obviously I've skimmed through this. You talked about Article VI and you say that's the bread and butter of the county health departments. And obviously -- I'm glad that you mentioned exactly more specifically what the needs are in your ask for this particular year, but obviously we have to deal with the lion in the room first. You would agree with that.

And so my question to you is in order to make sure that you get the revenues that you rightfully desire, I mean, understanding that it's going to be a bucket and it's obviously full, but are you open to possibly, if necessary, in order to make sure that services are provided to all of the counties in New York State, the possibility of raising revenue? Have you thought about that, or you haven't really thought about that in the process of putting this comprehensive package together?

MS. RAVENHALL: You know, I think
economic stability and raising revenue is always something that's beneficial to the state and something that we'd like to see.

In terms of funding local health departments, one of the most important things is anytime there's a new expanded mandate that the state puts into law that's protective and important, there has to be some kind of flexible funding that covers, you know, things like fringe so that we can expand our workforce and hire new staff to take on these mandates. So that's something that I would want to reinforce.

But understandably, revenue and economic stability is important for the state.

DR. GUPTA: So some of those things, as you have -- when I was speaking about, we do the core public health function, which nobody else will do that, to protect the health of the community.

So usually in the healthcare sector you can do fee-based. Here, there's no fee-based, because our mission is to protect
everybody. So the revenue is not directly
attached in those services because these are
esential, to make sure everybody is treated
in the same way.

If that answers your questions. Like,
for example, in lead --

SENATOR JACKSON: Lead poisoning.

DR. GUPTA: Right. So in the lead, it
is very crucial that we are there to address
the need of the child, to reduce the
childhood exposure. That means we have to
not only monitor the lead levels when they
come to our doors, as -- in the local health
department, but to make sure that we put our
workforce to make sure they do house
inspections, they do case management.

And these are not typically
revenue-generated, because they are not part
of the healthcare system. So I as a
commissioner, I came from the healthcare
system where, if I did that service, then I
can charge and bill. Here, this is part of
the public good which a community does.

SENATOR JACKSON: Thank you. I saw
that in your presentation, and that's very
good. But obviously we have to deal with
this bigger picture, including everything
else.

DR. GUPTA: Right.
SENATOR JACKSON: Thank you very much.
DR. GUPTA: Thank you.
CHAIRWOMAN KRUEGER: Thank you.

Thank you very much. Appreciate your
testimony tonight.

MS. RAVENHALL: Thank you for the
opportunity.

CHAIRWOMAN KRUEGER: Thank you.

Feeding New York, Dan Egan. Then up
on deck next, New York State Nurses
association, followed with Medical Society of
the State of New York.

(Discussion off the record.)

CHAIRWOMAN KRUEGER: Good evening.

MR. EGAN: Good evening. How are you?

Thank you all for the opportunity to speak
this evening -- I'm going to go with
evening -- and also for your long standing
support to food charities. My name is Dan
Egan. I'm the executive director of Feeding New York State. We are the membership organization of the nine Feeding America food banks in New York State. Last year our food banks provided over 184 million pounds of food to New Yorkers in need, and that included 60 million pounds of fresh produce.

We have a hunger problem in New York State. Today, as we all sit here doing this important work, there are food bank trucks on the road delivering donated food to our hungry neighbors. Just down the road from here, people have been known to line up at midnight for trucks that they know won't be there till midday. They're not teenagers lining up to see a concert or get the next iPod, they're there committing that kind of time because their families need the food.

In New York City people cheer when they see the City Harvest truck coming. They know the drivers, they know that truck is going to be full of good healthy food, and they're that happy to see them. Our state is filled with people who have never tasted the
very food that's grown by New York State
farmers because they've never had the
opportunity to buy fresh produce.

This hunger exists in every county of
our state, from Chautauqua to Clinton to
Suffolk. About 11 percent of all New Yorkers
and 17 percent of children are hungry. Most
of these folks are in households with jobs,
but the jobs do not pay enough, and due to
federal SNAP policy decisions, the situation
is about to get worse. Our colleagues at
Hunger Solutions estimate that over 110,000
New Yorkers are about to be affected, and
48,000 will lose benefits in April. And to
make up the gap for the food they're not
going to have will take about 27 million
pounds of food.

The tragedy is that this problem of
hunger is completely avoidable. New York
State farmers grow about 18 billion pounds of
produce every year, of which 1.2 billion
never leaves the farm -- that's billion with
a "b." It never leaves the farm because they
couldn't find a market. So this perfectly
good food is wasted. We're growing more than
enough food to feed everyone in this state.

And this is where food banks come in.
Food banks are the bridge between hunger and
food waste. We obtain donations of good but
unsold food and distribute it to those in
need. We work with farmers, food processors
and other donors. We're doing a lot now --
as I said, millions of pounds a year -- but
with your help, we could do a lot more.

I have all the science and the
statistics in my written remarks, so I won't
repeat all that here. But I think you all
know the effect that hunger has on people.
And the truly important thing you need to
know is that this is not an unsolvable
problem. It's a big problem, but it's not
unsolvable. And you here today have the
power to make a big difference.

So we're asking you for three things.
First, the Department of Health has the
Hunger Prevention and Nutrition Assistance
Program, or HPNAP. The Governor's budget set
that at just over $34.5 million, which is
about a half-million-dollar cut from last year. And at minimum, we ask that you restore that funding. The Legislature did this last year, and we thank you for that action. But it would be very disruptive to the charities that depend on this flow of money to have to make cuts in the middle of a contract year.

Second, HPNAP has not been increased for several years, yet the Governor has a goal to reduce hunger by 10 percent by 2024. With a $6 million increase in HPNAP, we can get additional staff and cover other operational expenses so that we can provide far more service.

And third, we've worked closely over the past year with the Department of Agriculture and Markets on a plan to build a statewide produce program that would link New York State farmers to New Yorkers who are hungry. This plan would link any farm in the state to any food bank, and thus to any community in need. It would provide milk and a huge increase in fresh produce distribution.
to our neighbors who are in need. We're seeking $6 million for this new program, and funding at this level could increase produce distribution by tens of millions of pounds.

Together, these two initiatives could completely close the new gap that we're about to see being created by the federal SNAP cuts.

So I thank you for the opportunity to speak today. I'm running out of time. If you have any questions, I'm happy to answer them.

CHAIRWOMAN KRUEGER: Any Senators?

Senator Jackson.

SENATOR JACKSON: Hey, Dan. I just -- I didn't have a question, but I want to thank you for coming in and giving us the details of how much food is available to feed those that really need. So I want to thank you on behalf of all of those individuals that serve the individuals that receive them, and I see that all over New York City wherever I go.

Thank you.

MR. EGAN: Thank you, sir.
CHAIRWOMAN WEINSTEIN: Assemblyman Cahill.

ASSEMBLYMAN CAHILL: Yes, thank you.

Hi, sir. Welcome. Just a quick question to ask you if you're familiar with the programs that are taking place in Ulster County right now with regard to a combination of assuring that otherwise wasted food would get appropriately composted or a partnership between restaurants, grocery stores and food banks.

MR. EGAN: Yes, sir, that's actually something that happens a lot all over the state. Some people call it food rescue. There's also a lot of gleaning projects down that way. So yes, I'm familiar with both. They're really commendable.

Both those sources of food put very high-quality food, top-quality food into the hands of people who need it, and they would not otherwise have access. I was talking to a food bank staffer just a few weeks ago who was providing broccoli to --

ASSEMBLYMAN CAHILL: We won't hold
that against them.

MR. EGAN: -- food pantry clients -- broccoli? (Laughing.) She was talking to a 12-year-old girl, and she said, "Would you like some broccoli?" And she was going to show her simple ways that it could be prepared. And the girl said, "Well, I don't know, I've never eaten broccoli." She'd never eaten broccoli because her family couldn't afford it.

So it gets worse. Behind her was her mom, who was maybe 30, 40 years old. And so our staff person said to her, "Well, would you like some broccoli?" And she said, "I've never eaten fresh broccoli either."

So there are people in this state reaching middle age who have not tasted the food that's being grown down the road from them.

ASSEMBLYMAN CAHILL: Do you have a -- and this is a very quick question, hopefully a very quick answer. Do you have any statistics on the actual cost of doing these projects on a -- you know, relative to other
hunger initiatives?

MR. EGAN: Relative to?

ASSEMBLYMAN CAHILL: Like a food program. Where we have to go out and buy the food and prepare the food and --

MR. EGAN: Probably the closest I can do is tell you that Feeding America, which is the national food bank organization, they estimate meal costs throughout the country. And their estimate is that the average meal cost in New York State is about $3.14. Now, good luck getting a meal at that price in New York City. But that's the statewide average.

We can typically provide about four to five meals for every dollar of funding that we have. So it's far more effective, of course, than, you know, participating in the normal food market.

ASSEMBLYMAN CAHILL: Thanks so much.

CHAIRWOMAN KRUEGER: Thank you. No questions. I just want to say thank you very much for your work.

I started in food banking in 1981 at
the Cleveland, Ohio, Food Bank, started the
New York City Food Bank in 1983, have taken a
look at your proposal for the new sort of
farm-to-provider. It's exactly what we were
hearing forever. If we could just figure
out, you know, how you coordinated from the
farms to transportation to the emergency food
providers or food banks, it was a win/win.
So I'm looking forward to working with you on
that.

    MR. EGAN: Thank you. Appreciate
    that.

    CHAIRWOMAN KRUEGER: Thank you.
    Next up, New York State Nurses
    Association, then Medical Society, and then
    Physicians Assistants. A little theme of
    providers of healthcare.
    And around this time I'm supposed to
    point out to people who feel like they have
    to run to get a train to get back to New York
    City, we still will take your testimony, it
    still goes up online. But you're
    comfortable, you've been here all day. You
    all look very relaxed up there. So we're
just -- that's okay, you're allowed to sleep, you're not on camera. We, on the other hand, no sleeping up here.

Good evening.

MS. JORDAN: Good day. My name is Cecilia Jordan. I'm the area director for New York City Health+Hospitals and mayoral agencies, and I'm here today on behalf of the executive director of the New York State Nurses Association -- NYSNA -- Pat King.

I want to thank the members of the joint committee for the opportunity to testify today. NYSNA represents over 42,000 registered nurses across New York State, and our members strongly support universal high-quality healthcare for all New Yorkers regardless of ability to pay. Our members share a commitment to provide care for our communities that is consistent with professional standards and nurse-to-patient staffing ratios that allow us to do our jobs under safe and fair working conditions.

We have provided the committee with a full copy of our testimony, and our members
will be sharing our concerns in more detail
during the session. So I will focus my
testimony today on a few key areas of concern
in the proposed budget.

This year's Executive Budget is
primarily focused on addressing a projected
$4 billion overrun in the state's
self-imposed, quote, Medicaid global cap.
The state has already imposed midyear
actions, including a 1 percent
across-the-board cut in Medicaid
reimbursement rates that will save as much as
$851 million a year. In addition, the
Governor has convened a new Medicaid Redesign
Team, MRT, to find an additional $2.5 billion
in Medicaid spending cuts.

I want to say at the outset that we
are opposed to any changes in current
Medicaid programs that negatively affect the
available of services or the quality of care.
This is a priority for NYSNA.

Regarding the MRT, we have two main
concerns. First, that the MRT must include
strong representation of direct-care workers,
healthcare advocates, and end users or consumers of Medicaid services, and they must have an equal voice and vote. The MRT cannot be perceived as packed in favor of providers.

Second, we are opposed to the mandate that the MRT finds $2.5 billion in Medicaid cuts. However, we are not opposed to efforts to improve the efficiency of Medicaid-funded health services, and we support efforts to identify and root out fraud and waste.

We also have to remember, though, that the 6.2 million New Yorkers receiving Medicaid are dependent on these services and that Medicaid monies are vital to our safety-net hospitals and other providers.

That being said, NYSNA believes that cutting Medicaid funding for the sake of cutting is the wrong approach. First, we believe that the $4 billion in cuts amounting to more than 5 percent of current spending will necessarily impact patients. You can't take that much money out of the system without causing some people to lose access to services or affecting the quality of care.
Second, we believe that cutting Medicaid is financially short-sighted and counterproductive. The Governor and the Legislature rightly called out the 2017 Trump tax cuts for corporations and the ultra-rich as a massive giveaway that was paid for by working people in New York. New Yorkers pay $22 billion more in federal taxes than we receive back from the federal government. The cap on state and local tax deductibility may add another 15 billion a year to that imbalance.

Given this inequity, we believe it is foolish to reduce state spending on needed Medicaid services when every dollar we cut costs us $1 to $1.50 in lost federal matching money. If we cut Medicaid by $4 billion, we save $2 billion or less, but the Trump administration gets to keep the rest, and our patients pay the price.

Third, we believe that we should be seriously considering revenue enhancements to close the Medicaid gap and maximize federal matching money. Areas to consider include
increasing corporate tax rates; target fees
or taxes at corporate and business entities
that will earn windfall profits in
healthcare -- after all, under the new
federal tax law, businesses are allowed to
fully deduct their state taxes; fully or
partially reinstitute the stock transfer tax,
which on its own could fund the entire gap.

Any discussion about restructuring
Medicaid must go beyond cost-cutting targets
and seriously address the way in which
existing spending is distributed.

The 1 percent across-the-board cut in
reimbursement rates, for example, was a
mistake because it did not distinguish
between profitable hospital networks.

We are also concerned about staffing
ratios -- sorry. Finally, before concluding,
we would also encourage the Legislature to
seriously consider the inclusion of
nurse-to-patient ratios in the final budget,
particularly if there are to be cuts in
Medicaid funding. Staffing ratios protect
the quality of care and help to ensure that
wasteful, unnecessary or preventable services are reduced, as there are fewer admissions, readmissions, financial penalties, nurse and other worker turnover costs.

We are also concerned about the provision to change professional practice standards in the budget that could impact patient care and safety. The budget proposes to greatly expand the list of vaccines and services that may be administered by pharmacies. This is a complex issue that needs greater thought and study. We believe these types of practices should not be addressed as part of the budget process.

Once again, I thank you for the opportunity to speak today. I look forward to meeting with you to discuss our concerns.

CHAIRWOMAN KRUEGER: Thank you. That was the fastest. Thank you.

Senators? Senator Rivera.

SENATOR RIVERA: Thank you, Madam Chair. And thank you both for being here.

MS. JORDAN: Thank you.

SENATOR RIVERA: So I will ask again,
as I am asking everyone else, were you --

have you been contacted by the administration

for -- to participate in the MRT process?

MS. JORDAN: No, we were not, Senator.

SENATOR RIVERA: You have not been

contacted by them.

MS. JORDAN: No, we were not.

SENATOR RIVERA: But obviously, as I

can see from your testimony, obviously you

believe that not only is it an important

process, but that representation of

front-line workers and actually people who

provide services would be quite important in

that conversation.

MS. JORDAN: Absolutely.

SENATOR RIVERA: Does the Nurses

Association have a position on the Medicaid

cap?

MS. JORDAN: Well, at my level of the

organization, I have not had those

discussions. But I think that we would be

interested in exploring that further, as the

majority of our members do serve patients

that are already living in and serving in
disproportionately affected communities, so
that would be something that would adversely
affect our patients and the communities that
our workers work in.

SENATOR RIVERA: Thank you for the
work that you do every day to make sure that
we're healthy, and thank you for being here
today.

MS. JORDAN: Thank you, Senator.

SENATOR RIVERA: Thank you,
Madam Chair.

CHAIRWOMAN KRUEGER: Robert Jackson.

SENATOR JACKSON: First let me thank
NYSNA for coming in. And when you started to
read, I didn't think that you were going to
finish everything that you had to say within
five minutes, but you sped up real quick.
Which is a good thing, because you finished
basically right on time.

And I was looking, even before it was
one minute into your speech, as soon as I got
looking here, and it says increase corporate
tax rates, increase the millionaire's
surcharge, target taxes and fees at corporate
and business entities that will make windfall
profits in healthcare. Reinstitute the stock
transfer tax.

Well, you sound like you want to make
sure that your nurses continue to work to
provide the services that they rightfully
give the people of New York State. And so
I'm glad that you came forward in saying that
yes, we look forward to the, what is it, the
Medicaid Redesign Team No. 2. But you don't
depend on that to get the job done.

MS. JORDAN: No, sir.

SENATOR JACKSON: And so that's a good
thing. And I'm glad that you are saying some
of the things that I'm saying, and some of us
are saying, that we have to raise revenue.
You just can't cut, cut, cut, cut, cut. And
I agree that you can make some changes and
you can deal with a lot of the fraud that's
in the system. I mean, obviously, no one
wants fraud to happen, you know what I mean?

But I thank you for your testimony.
And I hope that groups like 1199, NYSNA, and
other activists and others will be part of
the redesign team so that, you know, it's not just one-sided, which is very, very important in this particular matter.

But obviously -- I got this and I'm going to read the details, and obviously in the last paragraph you said "As more concrete information emerges and we continue our review of these and other Executive Budget proposals related to healthcare, including the proposed HCRA revisions, we will provide more detailed analysis and position statement." Well, we look forward to more detailed statements.

MS. JORDAN: Thank you, sir.

SENATOR JACKSON: Thank you, Madam Chairs.

CHAIRWOMAN KRUEGER: Thank you. Thank you both for coming. We appreciate it.

MS. JORDAN: Thank you.

CHAIRWOMAN KRUEGER: Next up we have the Medical Society of the State of New York, I believe Morris Auster. And then for people getting ready, Physicians Assistants afterwards, and then Empire Center.
MR. AUSTER: Thank you very much, Senator Krueger. And thank you for the opportunity to present our perspectives on the State Budget.

MSSNYS represents physicians of every specialty, every region of the state, and every type of practice construct -- small group, large group, hospital employee -- delivering care to patients every day across the State of New York.

Our written testimony touches on a number of different aspects of the Governor's budget, but I really just want to limit my comments to a few different areas. I always like to start with some nice things, and I have to say there are some positive aspects of this budget. Certainly, one, to be able to limit the sale of flavored tobacco products and to help prevent the health risks associated with the vaping. Of course, also want to thank Senator Hoylman and Assemblymembers Bichotte and Rosenthal for also advancing legislation in that area.

Legislation to require the
registration and oversight of PBMs. And again, on the same level, Assemblyman Gottfried, Senator Breslin, Assemblyman Cahill, Senator Rivera have also been sponsoring that. Hopefully we can actually get a bill done this year in that area. And then also, given the pervasive complaints that physicians receive -- that we receive every day from physicians across the state about hassles they have with insurance companies, efforts to achieve some form of administrative simplification, including an administrative simplification task force, and a claims denial transparency report.

We also appreciate that the budget includes funding for the Excess Medical Malpractice Insurance program, but it has been reduced. And I think there should be some checking with the insurance industry whether that will be actuarially sufficient. Where we are very concerned -- and I think we've had some of the discussion earlier today, and I thank Assemblyman Cahill for raising it -- is that the budget has not
extended the historical language associated
with the Excess Medical Malpractice Insurance
Program.

You may be aware that New York has
liability costs that far exceed any other
state in the country, even similar-sized or
bigger states like California, Texas and
Florida.

Well, unless the state is looking to
enact comprehensive liability reform to bring
down these costs, and we always know that's
been a very difficult issue, this Excess
Program is absolutely essential for
physicians and for patients, frankly, at the
end of the day as well. With the exorbitant
premium costs and runaway verdict sizes we
have in our state, physicians cannot practice
in our practice without -- with a fear that
every time they treat a patient, their home
or assets could be at stake.

We appreciate the Legislature has long
recognized this critical balance that this
program has provided, and look forward to
that program being fully funded and extended
as it typically has been.

We're also concerned with the threat of further significant cuts to Medicaid payments. The New York Medicaid payment is already among the lowest in the country, and it was just made worse by that 1 percent cut. The direct physician payment is already a very, very small part of New York's overall Medicaid budget. With New York already having the dubious distinction of being the worst state in the country in which to be a physician, and with many physicians already being put in a position where they've been forced to become hospital employees based upon their own inability to keep a practice open, any type of cuts, let alone the potential cuts that could come along with a $2.5 billion savings target would be -- would just exacerbate this trend. In fact, for many physicians it could be the death knell for these community-based physician practices.

Last but certainly not least, we are extremely concerned with the scope of the
physician disciplinary proposal in the Article VII bill. Simply stated, these provisions have the potential to unfairly destroy a physician's career. New York's physician disciplinary process already provides ways by which the Commissioner of Health can bypass the required due process protections when there are exigent circumstances.

The overwhelming number of complaints that are filed against physicians result in no actual action being taken, yet any complaint -- based upon the language, any complaint, no matter how minor, could theoretically become public or result in an immediate summary suspension of the physician at the whim of the commissioner, without any fair due process first.

With Google, Yahoo and other search functions, a public report that a physician is under investigation or has been summarily suspended, even if subsequently overturned, would make it nearly possible for that physician to get their reputation back.
We're always anxious to find ways to address gaps in our disciplinary system to protect the public, as we did a couple of years ago with the provisions relating to when a physician has been accused of a felony not related to healthcare. But this proposal that's been put forth goes way too far. We urge that it be taken out of the budget.

We have many other items in our written testimony that identify, but for the sake of time, you can read them at your convenience. And we thank you for the opportunity. I'm happy to answer any questions.

CHAIRWOMAN KRUEGER: Senators?

Senator Rivera.

SENATOR RIVERA: Yes.

Hello, Moe, how you doing?

MR. AUSTER: How are you?

SENATOR RIVERA: Thank you for hanging out.

So has the Medical Society been approached by the administration for its potential participation within the MRT
process?

MR. AUSTER: We have not. To be fair, we have asked that if one gets put together, we would like to make sure there is a representative of organized medicine. But we have not been directly asked to be a participant.

SENATOR RIVERA: And to be fair, everyone except the administration has kind of said the same thing.

But -- okay, so is there a position that the Medical Society has on the Medicaid cap?

MR. AUSTER: We do not have a formal position on it.

I will say we do not -- physicians do not get cost trend increases each year. The fee schedules are where they are. There have been isolated increases over the years. So I guess, theoretically, if you were to raise the cap, that could make it likely to have some kind of further increase in the future.

Like I said before, our rates are far lower compared to many, many other states.
Others base it based upon a percentage of Medicare -- near Medicare. Ours is like 50 percent of Medicare. So theoretically, if you raise the cap, that could make it more likely, but we do not have an official position on it.

SENATOR RIVERA: Okay. Thank you, sir. Thank you, Madam Chair.

CHAIRWOMAN WEINSTEIN: Assemblyman Byrne.

ASSEMBLYMAN BYRNE: Yes, thank you for being here.

And I was hoping that you could just elaborate a little bit more on that section of the Executive Budget, I think it's Part L, with the section regarding the Office of Professional Misconduct, and just the concerns I think that are raised that if someone makes an accusation, this could not -- it could completely, in my mind, damage someone's entire career. Because like you said, with Google and Yahoo, how is someone supposed to go back to their life and to work with some accusations out there?
I mean, I have some concerns about due process in general on that. We've taken steps outside of the healthcare side, and out of this committee, just to protect everyday citizens from trying to be grouped into -- you know, being put on the internet without their due process.

If you could elaborate a little bit on that. And I also wanted to ask you just one other question. I see in your testimony the opposition from MSSNY for recreational marijuana. And I do have some concerns that while the Governor has put forth some proposals for stricter tobacco controls or even the marketing practices, at the same time we're talking about potentially legalizing marijuana for recreational use.

And some of you have already said, in the previous testimony, that could be a potential revenue raiser to offset the Medicaid gap. I have some concerns about that but would like to just hear your thoughts and see if you can elaborate on it.

MR. AUSTER: Yes. Well, on the
disciplinary front, we have long maintained
that we needed to have a balanced system
within the disciplinary process. We have
recognized over the years that there are
times -- there's a process, there's an
investigation, there's an investigation
committee, there's a hearing committee. We
have recognized over the years in creating
the process that there are times based upon
certain circumstances when you do need to
jump the line and take expeditious action
based upon a certain circumstance.

You have that standard now, with the
imminent danger standard that's been put
forward in the law that we believe addresses
the circumstances. You also have the
circumstance now where once -- right now --
last year I believe there were 9,000
complaints that were filed with the OPMC, of
which 250, I think, ultimately were referred
for charges -- not even final disposition,
but just had charges brought against them.

Once you reach the stage of actual
formal charges, that information can be made
public. The concern we have is when before
the time that it actually becomes -- before
the time you actually realize there is a
potentially very serious situation going on,
that information can be made public. And
once that information is made public, there's
no chance a physician can ever get their
reputation back.

We feel that there's an adequate
balance right now. But like I said, we are
always anxious to find ways -- if there are
gaps in the process, we are anxious to find
ways in which we can, you know, work
towards -- to address those gaps. But this
goes off in a completely different direction.
And frankly, I'm not even sure what it's even
doing in the budget in the first place.

And then on your question on
marijuana, we continue -- the Medical
Society, like many other organizations, I
think like the PTAs, like the county health
officials, we continue to have strong
concerns with the legalization of
recreational marijuana. There's been
information that the CDC just put out that
even with legal sources, that that's been a
significant cause of instance where you've
had vape-borne injury in other states. And
we certainly understand the need to try and,
you know, address certain societal wrongs.
We think the Legislature did an important
step last year through the enhancement of
decriminalization last year. But based upon
some public health risks that we've seen in
others states, we still continue to have
significant concerns.

ASSEMBLYMAN BYRNE: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

CHAIRWOMAN WEINSTEIN: Thank you, Moe.

CHAIRWOMAN KRUEGER: Thank you very
much for being here tonight. Next up is the
New York State Society of Physician
Assistants.

MS. REGAN: Good evening.

CHAIRWOMAN KRUEGER: Good evening.

MS. REGAN: It definitively is
evening. And I thank you for the opportunity
to be here to give this testimony on how PAs
can be the solution to help New York State's quadruple aim, to increase access to high-quality, cost-effective care and enhancing provider satisfaction.

PAs represent a transformational opportunity to positively impact the state's bottom line while improving patient access to care in primary and specialty care settings, including health promotion and disease prevention. Timely, quality access to care reduces a patient's need to seek costlier visits to urgent care for non-urgent visits and allows for making a timely diagnosis of disease states, conditions more costly to treat at an advanced stage.

In an inpatient setting, a PA's ability to see Medicaid managed care patients facilitates throughput, decreases length of stay, thereby reducing significant cost and creating bed capacity. PAs in specialty care can increase access for Medicaid patients who wait sometimes months to be seen by a specialist.

PAs are trained in medicine, and we
practice very autonomously with our physician colleagues and other members of the healthcare team. This effort extends from the state's pre-hospital-care footprint through end of life and palliative care decision-making. This was supported on a bill passed in 2010 and further clarified in a memo issued by Assemblyman Gottfried in 2019. PAs have unrestricted licenses, like our physician colleagues. That is, we can see patients of every age and patient acuity in every healthcare setting.

As medical staff, PA quality assurance is overseen via the same infrastructure as our physician colleagues. Hospitals, outpatient facilities, long-term and short-term care, patient-centered medical homes are all entities that PAs see patients in. This makes PAs a very versatile healthcare workforce solution, incorporating genetic and social determinants of health.

Despite this, payers, including New York State Medicaid managed care entities, do not credential PAs nor allow
them to have patient panels. This restricts
patients from identifying PCPs in their
community. It also forces them to rely on
urgent cares if there are not enough PCPs
available to them. As we know, urgent cares
are an invaluable resource, but they are not
primary care entities and are more costly.

Additionally, if a PA is not
credentialled by a New York State managed care
plan, a patient pays a significantly greater
copay to see a PA, as a visit is deemed an
out-of-network visit by the payer.

I received a phone call from a PA who
practices in Westchester. He's a primary
care PA. And when Medicaid managed care
patients come in to see him, they are
required to pay a $75 copay. They walk into
that same visit to see the primary care
physician that he collaborates with, and that
patient's copay is $25.

The important issue is of concern
across the state. It has been explained to
NYSSPA that leaders in One Brooklyn Health
are looking towards PAs as an integral part
of their quality, cost-effective workforce
solution and are frustrated about the
inability to enroll PAs with New York State
managed care. There are PAs across this
state who see patients in communities, rural
and urban, who cannot recruit physicians; PAs
are often the only medical providers
available to them.

PAs are an integral component to
New York State Medicaid shared saving plans
and are capable of leading care teams. There
are many municipal workers across the state
whose insurance does not credential PAs.
This creates the same costly lack of access
to care as the New York State Medicaid
managed care paradigm does. For our
downstate legislators, Emblem Health, which
covers FDNY, NYPD and other municipal
workers, is one.

This is an administrative fix that
needs timely conversation to ensure policy
and contract language to include PAs.

There is a physician shortage, and
many physicians in practice are experiencing
burnout. One of the main causes of burnout is the sheer volume of patients. PAs are the solution. By having all New York State Medicaid and third-party payers credential PAs and allow them their own patient panels, access to primary care and specialty services will be increased.

There are over 14,000 licensed PAs in New York State, and State Ed is adding a thousand licenses a year. I have sat through many hours of testimony today about solutions to New York State's healthcare problem. Not once has the PA profession been named as a solution, a profession that is capable and competent. There are 23 accredited PA programs in New York State, with five in the pipeline.

We are a young workforce. I will put on public record I am at the pinnacle of the aging population. The majority of the PA workforce is female and less than 45 years of age.

As a stakeholder in this, NYSSPA looks forward to working with the New York State
Legislature and the Medicaid Redesign Team to meet the challenge and be part of the solution. We were not part of MRT I. We have not been asked to be part of MRT II -- sorry, Gustavo, I'll take your thunder earlier -- and we look forward to partnering autonomously with our physician colleagues and our Legislature to take care of the patients of New York State.

CHAIRWOMAN KRUEGER: Thank you.

Any questions? She got the answer already. Anyone else?

CHAIRWOMAN WEINSTEIN: Assemblyman Byrne.

ASSEMBLYMAN BYRNE: First, I know we're trying to limit our comments, but I want to thank you for being here, Maureen. And I do think that physician assistants are definitely one of the tools, part of the answer to our healthcare system increasing access to care. And I just want to thank you for being here.

And my wife is one of those statistics, and I hope I won't get in trouble
for saying 35, so she's under that number,
and she's actually working right now. And
she'll tell me that -- always reminds me that
it's -- I'm happy that that was correct, when
you were on the TV there, because it's
physician assistant, not physicians
assistants.

MS. REGAN: Thank you. I had that
corrected.

ASSEMBLYMAN BYRNE: Good job. Thank
you again.

CHAIRWOMAN KRUEGER: Anyone else?
Then thank you very much for being here.

MS. REGAN: Appreciate it. Thank you.

CHAIRWOMAN KRUEGER: Great. Next up
is Bill Hammond, from the Empire Center.

MR. HAMMOND: Good evening.

CHAIRWOMAN KRUEGER: Good evening.

MR. HAMMOND: Thank you all for having
me to testify, and thank you for sitting
through all of this.

As I say in my written testimony, the
main problem with the Governor's budget is
that it barely exists. It's really -- the
normal process is for him to lay out a series
of detailed spending proposals, normally he's
looking to control Medicaid spending in some
way. But this time, instead, he delegated it
to the Medicaid Redesign Team. The Medicaid
Redesign Team doesn't exist yet, as has been
discussed. The timing is very bad.

It's possible -- since we don't know
the membership, it's kind of hard to know,
but it's possible the MRT will come up with a
great plan. It's just that it should have --
if you were going to do it that way, it would
have been better to have started several
months ago.

The result is that we have a big blank
spot where the Medicaid budget should be, and
that is kind of a continuation of a long-term
problem of delaying action that is necessary,
and withholding information. And those --
that pattern is what brought us to this point
today. That's like the proximate cause of
our deficit.

He does have one -- the Executive
proposal does include one concrete concept,
that's the new deal with the county share of Medicaid. I have to say that that's about shifting costs, it's not about controlling them, and it's shifting them in the wrong direction, I would say.

It's also discouraging that there's been already a discussion of what the Governor referred to as "additional industry revenue." That sounds an awful lot like taxes on health insurance. We already rely very heavily on health insurance taxes. This makes our coverage less affordable for people who buy it, for the employers and the consumers who buy it. If those rates go up too high, people are going to lose coverage, and that's going to put more pressure on the Medicaid budget.

I think it's important to emphasize -- there's been a lot of talk about the 2.5 billion. And that is -- that's a large number. It's roughly 10 percent of the projected spending in 2021. But to put this in perspective, if you look in the financial plan, the total Medicaid spending for the
year we're in now is projected at
$26 billion, and the amount of the Governor's
budget for 2022 is also $26 billion. There's
a small decrease, but it's essentially flat.
And if you look back at what you approved
last March, that was $24 billion.

So if you do the full 2.5 billion in
cost savings that the Executive is proposing,
you end up with a budget that's $2 billion
higher, 8 percent higher than what you
proposed last year. And it's double digits
higher than what you proposed two or three
years ago.

That is the rate of growth that we're
seeing in Medicaid. It's growing so fast you
have to take a pretty big crack at it just to
keep it flat.

And when I hear providers say that if
you do this, if you take that 2.5 billion,
you're going to -- that people are going to
close and people are going to lose their
services, the subtext there is if we don't
get a 10 percent increase, we're going to go
out of business. And I don't think that's
sustainable.

I guess another point I would make is we're not talking about -- we shouldn't be talking about across-the-board cuts where everybody has to take a 10 percent hit or anything like that. You should be targeting the reforms, the cost savings, the efficiencies to the areas where it's most necessary.

I will say that I think you should reject the HCRA taxes, the Health Care Reform Act taxes. You should preserve the freeze, if not lowering the local share. And then you need to look for -- you need to focus on the areas where spending has grown most quickly.

There's been a lot of talk about long-term care, and I will agree some of that is the result of demographics. I looked up a couple of numbers. In the two-year period from 2016 to 2018, the over-75 population grew by 4 percent. And that, in the context of New York State, where our population is actually shrinking -- 4 percent growth.
That's a lot by the standards of New York State.

In that same two-year period, though, managed long term care enrollment was up 31 percent in two years. So yeah, there's some demographics going on, but that's not the primary thing.

So I've run out of time, but I'm happy to -- if you have any questions, I'm happy to answer them.

And in anticipation --

SENATOR RIVERA: No, no, no, sorry, sorry, sorry. I need to ask the question.

(Laughter.)

CHAIRWOMAN KRUEGER: Senator Rivera next.

SENATOR RIVERA: Mr. Hammond, officially and for the record, sir -- you are being recorded, sir --

MR. HAMMOND: Yes.

SENATOR RIVERA: For the record, have you been contacted by the Cuomo administration for your potential participation in the MRT? Be honest, sir.
MR. HAMMOND: I have not. I think Eric Linzer nominated me --

(Laughter.)

MR. HAMMOND: -- but I have not been contacted by the Governor's office.

SENATOR RIVERA: I'll just say, also for the record, we disagree a lot, but I'm very, very thankful at the way that you approach this, the -- it is -- I have learned a lot from actually reading some of your -- a lot of the analysis that you do, and I appreciate the fact that there's somebody coming from a different perspective and still come to trying to solve the problem. I appreciate that. And I would hope -- I mean, because I don't know who's in the MRT. I mean, if -- it would be -- let's just dream of a situation in which all the different folks that we talked about are there, and we're both there too. One can dream.

MR. HAMMOND: Thank you. Thank you for saying that, Senator.

SENATOR RIVERA: Thank you for hanging
out, by the way.

CHAIRWOMAN KRUEGER: Assembly?

All right, well then I also want to
just thank you for your work. I feel like
Gustavo. We disagree on the analysis, but I
appreciate that you do it.

So again, we know why Medicaid is
growing. Right? We are getting older, and
older people spend more money on healthcare.
We're getting poorer as we get older, so
they're on Medicaid. We have this system
that the Governor proudly said 95 percent of
New Yorkers are insured. But they're insured
because when the ACA went into effect and we
created the New York State of Health and
everybody was told, Go find out which
insurance is cheapest and best for you --
because otherwise you're going to get a
penalty if you don't sign up -- 40 percent of
the people who showed up were eligible for
Medicaid.

So, you know, the only place I think I
disagree with you is it's not like a surprise
that costs are going up in Medicaid, it's
because the population went from 4.7 to
6.2 million people who were eligible and
participating. Do you disagree those people
aren't eligible for Medicaid?

MR. HAMMOND: Well, okay, there's two
points to be made here. First of all, the
enrollment has been -- overall enrollment has
been flat for about four years. And so I
would have expected that spending would have
stabilized by now. You might have seen
like -- you know, when people are first
enrolling, you would expect a surge in
expenses. But the enrollment is not surging
anymore, it hasn't been surging for a number
of years.

With respect to do -- are the people
on there eligible, I assume that most of them
are.

I would say there's been any number of
audits, both by the federal government and
the State Comptroller, and every time they
audit it, they find pretty substantial
percentages of people where, when they look
at the records and they line them up against
the eligibility guidelines, they don't appear
to be eligible. And when I say substantial
numbers, there's one federal audit that found
15 percent were either -- did not match the
eligibility or there weren't enough records
to verify that they matched the eligibility.

So I think there is probably some
number of people on the rolls who arguably
don't belong there. And if you were looking
for strategies to save money, checking for
that kind of thing, checking to make sure
that they aren't dead, checking to make sure
that they aren't already enrolled in some
other insurance and we're still paying
premiums for them, that's, you know,
healthcare management 101.

CHAIRWOMAN KRUEGER: Thank you very
much for being here tonight.

CHAIRWOMAN WEINSTEIN: Excuse me. We
have a question from Assemblyman Byrne.

ASSEMBLYMAN BYRNE: Sorry. I wasn't
going to ask a question, because I know it's
getting late, but I figured you're here and I
saw you up in the audience, Bill, here the
entire time.

   So I am kind of curious if you had any thoughts based on the testimony of the commissioner and Medicaid director, the Department of Health commissioner, when we were talking about specifically when this budget deficit started to build last year and the fact that they shifted the 1.7 billion from one fiscal year to the next. It seems to me that that wouldn't be best practice for most people in accounting. But also it just seems that there was an opportunity to maybe get ahead of this months ago and start this process maybe earlier, and now we're kind of under the gun.

   But I was curious what your thoughts were on that. I don't even know where the authority comes to shift the payments from one fiscal year to the next, because I get the thought that we vote on the budget for one fiscal year. But if you could just elaborate and give us your kind of response on what you heard today.

   MR. HAMMOND: So I think the
overspending issue actually goes back maybe three or four years. It started relatively small. There was a disclosure in the middle of 2019 where they said we've been managing the timing of Medicaid payments going back to 2015. And it started in -- you know, I think it was 50 million, and it built. And I think I believe it got larger from year to year. And so 1.7 billion could be seen as kind of an accumulated deficit that was rolled forward.

I think that the time to disclose that kind of a situation, especially when you're getting into the third or fourth year of rolling over unpaid bills, is at the beginning of the budget process in January, so a year ago now. That would have been a good time to disclose it.

That way it would have been on the table for the Legislature to be aware that spending was higher than they thought it was. And they could have prepared a new budget that absorbed that increase one way or the other, either by efficiency reforms, which
would have been my preferred approach, or, if you're going to do revenue, the time to do revenue is during the budget process.

So delaying the payment, especially without public notice, guaranteed that the new budget was going to be out of balance. And not just by the amount of the delayed payment, but also by the amount of the higher spending level that you weren't aware of. So that's -- that's why I say that's the proximate cause of the deficit. It's not just the spending, it's also the management of that spending.

ASSEMBLYMAN BYRNE: Okay, thank you. I appreciate your time.

CHAIRWOMAN WEINSTEIN: Thank you.

Next we have, from the Schuyler Center for Analysis and Advocacy, Bridget Walsh, senior policy analyst.

And just if you're keeping score, the next is Medicaid Matters New York, then to be followed by the Pharmacists' Society of the State of New York.

Thank you.
MS. WALSH: Good afternoon. Thank you for the opportunity to address you today with our thoughts on the Executive Budget. My name is Bridget Walsh, and I am a senior policy analyst at the Schuyler Center.

The Schuyler Center is dedicated to policy analysis and advocacy in support of public systems that meet the needs of disenfranchised populations and people living in poverty. We often work in the areas that fall between multiple systems, including physical health and mental health, child welfare, human services, and early childhood development.

First, like many before me today, I'd like to mention our concerns with the Executive's plans for Medicaid. Medicaid is critical for children and families. In fact, 48 percent of New York's children zero to 10 are covered by Medicaid, and 59 percent of kids zero to 3 are covered by the Medicaid.

As we heard in many of the comments today, the MRT II has a tight timeline to generate proposals, and we believe it's
important for the Legislature to be engaged in this work to ensure that any recommendations live up to the Governor's admonition that proposals not impact beneficiaries or benefits.

We applaud the many calls we have heard here today from our colleagues and legislators that this new incarnation include a breadth of perspectives. We believe that this should include but not be limited to people with disabilities, family members of children covered by Medicaid, older adults, people in historically underserved communities, and people of color from the beginning of the process.

We're also very heartened, as I sat in the audience today, to hear many of your concerns about the Medicaid cost shift to localities. The executive proposal risks augmenting inequalities among communities and harming people in lower-income communities that have higher Medicaid enrollment and costs but less capacity to raise revenue.

Families in poverty receive assistance
from a range of services and programs funded and operated at the local level. We fear that diverting monies to pay Medicaid costs poses risks to the ability of local entities to fund these other services and may lead to other cuts that harm children and families.

On the issue of Early Intervention, the Schuyler Center is a member of the Kids Can’t Wait campaign that brings together individuals and organizations from throughout New York with the goal of bringing the Early Intervention and preschool special education systems into compliance with federal law and ensuring that young children receive the services and therapy they need in a timely manner.

We are also a member of the steering committee of Winning Beginning New York, which has carefully examined the EI landscape in New York. As you will hear from others today, New York's low payment rate for Early Intervention has driven providers out of the program, jeopardizing services for children across the state. We believe that the rates
remain too low, and that a rate increase of
10 percent should be extended to all EI
providers, evaluators, and service
coordinators to begin to restore their rates
to where they need to be to ensure that
children with developmental delays or
disabilities get the timely access to
services they urgently need.

We think that the pay-and-pursue
proposal is a modest step towards improving
the imbalance between government payers and
insurance companies, but the budget misses an
opportunity by not dedicating services to
increasing reimbursement rates.

The Executive Budget also contains a
number of measures and resources to improve
maternal mental health from pregnancy to
childbirth and the early postpartum -- and
the postpartum period.

We applaud the Governor's work in this
area, and we hope that you support those
initiatives. We also expect to have some
policy recommendations around maternal mental
health in the future, and we look forward to
working with you on those proposals as well.

We also ask that additional investments be made to support maternal infant and early childhood programs around New York State. You have information on that in your packets.

And the other issue we want to finally draw your attention to is a proposal in the Executive Budget that substantially changes the EQUAL program for adult homes. For many years, the Schuyler Center has worked with a coalition for adult home reform in advocating for improved community and supportive housing options for persons with psychiatric disabilities living in adult homes, and for improved conditions and a more robust oversight of adult homes.

The EQUAL program is a lasting legacy of years of hard work on the part of advocates. While the budget proposal does not cut the funding, the language proposes an overhaul to the program that restricts how the funding can be used. We are still working with partners to fully assess the
implications of these changes, but we are concerned that a change to the statutory intent of the program will further marginalize adult home residents. We ask you to look very closely at those proposed changes.

Thank you.

CHAIRWOMAN WEINSTEIN: You made it just in time, and there aren't any questions. Just so everybody knows, so all of the people who had submitted testimony in advance electronically, that had been shared by all of the members of the Ways and Means Committee and the Health and Insurance Committees, so people will have your testimony. Besides, it will be posted.

Thank you so much for being here.

Next we have Medicaid Matters New York, Lara Kassel, coalition coordinator, to be followed by the Pharmacists Society of New York.

MS. KASSEL: Good evening. Thank you very much for the opportunity to address you this evening. Thanks also to your staff for
being here.

I am grateful to be testifying earlier than I ever have before on behalf of Medicaid consumers and Medicaid consumer advocates. I would urge you in the future to figure out a way to mix up the witness list so that other advocates can also be testifying as early as I am.

Medicaid Matters New York is the statewide coalition representing the interests of the people who are served by New York's Medicaid program. You have my written testimony; I'm only going to provide a few points on it to you this evening.

Our membership is statewide. There are over 100 coalition members, including consumers, individual advocates, legal services attorneys, representatives from community-based organizations, and community-based providers, and we work together to advance the interests of Medicaid beneficiaries.

As you'll see in my written testimony, Medicaid Matters has some experience in MRT
proceedings. I bring perhaps some unique
date the lone consumer advocate on
the original MRT. So many of the comments
that were made today by you and your
colleagues and others who testified today
really resonated with me -- and I'm sure with
many of my colleagues within our coalition --
regarding the makeup of the MRT, regarding
the importance of meaningful consumer and
community input and feedback and, as has also
been indicated by Senator Rivera and others,
a meaningful timeline.

So -- and to answer Senator Rivera's
question, no, I have not yet been invited. I
have not been invited to sit in on an MRT II.

Regarding the global cap, our
coalition members have been coming to our
coalition-wide monthly group calls -- you
know, we operate very much as a grassroots
coalition. We get on the phone once a month,
we have a listserv, and people post freely on
the listserv for open dialog among the
coalition members. Our coalition members
have been saying for a number of years now
that the Medicaid global cap really must be re-examined, and in particular that there needs to be transparency about what the global cap is, how it operates, how it is used as a tool, and how decisions are made about what's in the cap, what's out of the cap, as far as real policy decisions about Medicaid finances and how things fit under the cap or don't fit under the cap. And those conversations within our coalition continue even as of today with traffic on our listserv.

I'd like to leave you, however, with the most important message that I have to deliver to you, and it hearkens back to the mission of Medicaid Matters and my job as the coalition coordinator. And that is to remind you and the Governor and state agency officials and really, frankly, all of us about the intent of the Medicaid program, and that is to provide coverage and access to services for low-income people and people with disabilities.

I'll share with you, because it's a
lovely visual -- we have a Medicaid stories packet, we published this a couple of years ago. Stories are always important, I think, to drive home the importance of programs and in particular Medicaid, and there are five stories of real New Yorkers to highlight and emphasize the importance of the program and remind us all that Medicaid is intended to be a coverage and access program for New Yorkers.

And I'll, just in closing, leave you with some comments that I got in response to a statement that we put out on the Governor's budget on Friday. We had many coalition members email me to say: Thank you for delivering the message, thank you for highlighting the importance of consumer advocacy and in particular representation on the MRT, perhaps re-examining the global cap.

But the message that resonated most to me and was most meaningful to me was one that I got from a coalition member who is a young woman, I think she's about my age, and she's someone who benefits from the CDPA program
and the Nursing Home Transition and Diversion Waiver. And she, in a very impassioned way, thanked me for delivering the message that Medicaid needs to stay strong for the people who rely on it every day.

CHAIRWOMAN WEINSTEIN: Thank you for being here. If you want to send an electronic copy of that report that you held up, we'll make sure that it's included with your testimony and post it online.

MS. KASSEL: Thank you, I'd be happy to. It's also on the Medicaid Matters website.

CHAIRWOMAN WEINSTEIN: Sure.

SENATOR RIVERA: (Indistinct.)

CHAIRWOMAN WEINSTEIN: She already answered your question. She answered your question in -- okay -- but she answered your question in your absence.

But -- Senator Rivera.

SENATOR RIVERA: Thank you.

Sorry about that. Took a quick bite, and so --

MS. KASSEL: Got it.
SENATOR RIVERA: I missed that you did answer the question, but I actually found a follow-up, because I was told -- although you have not been contacted to be part of the MRT this time, apparently you were a member in the original process.

MS. KASSEL: I was.

SENATOR RIVERA: And how were you contacted originally to actually be a member of the process?

MS. KASSEL: I received a call from someone in the administration, I don't remember who it was, and I was invited as the lone consumer advocate after Medicaid Matters put out a statement saying that it was inappropriate and irresponsible for the Medicaid Redesign Team to exclude consumer representation.

SENATOR RIVERA: And this was -- the timing of this, when -- do you remember around when the time was that you were included?

MS. KASSEL: I believe the announcement came in the State of the State
address in 2011, and we put out our statement shortly thereafter to say we were not aware that any consumer advocates or consumers themselves were on it, and the call came immediately.

SENATOR RIVERA: And I'm sure -- I would assume that you would want to -- again, maybe not you personally, but that you believe consumer representation in whatever they've managed to put together is absolutely essential for the product to be responsive to the concerns of consumers.

MS. KASSEL: It is absolutely essential. It would be a travesty for the same process that happened in January and February of 2011 to happen again.

SENATOR RIVERA: Thank you so much for your time.

Thank you, Madam Chair.

CHAIRWOMAN WEINSTEIN: Thank you.

Thank you for being here.

Next we have the Pharmacists Society of the State of New York, followed by the Pharmaceutical Care Management Association,
followed by Community Pharmacy Association of New York State.

MS. ENNELLO-BUTLER: Good evening, Senators and Assemlymembers and distinguished members of the Legislature. My name is Deanna Butler, and I am the executive director of the Pharmacists Society of the State of New York, PSSNY. I'm here today with PSSNY's president, Steve Moore, who is a licensed pharmacist and co-owner of an independent pharmacy in Plattsburgh, New York.

Thank you for allowing PSSNY to testify today. It is important to recognize the support that the leaders and members of both houses have shown for the issues that PSSNY has brought to you in the past. Thank you for recognizing the value that local pharmacists bring to your communities and to their patients. Many of your constituents rely on the community pharmacists they know and trust for medications as well as the additional support and extra services we provide.
Without rehashing the discussions already held today, it is the position of PSSNY that pharmacists must be adequately represented on the MRT II. While not originally included in the first MRT, pharmacists are the most acceptable healthcare providers capable of improving patient outcomes and lowering costs.

MR. MOORE: We are here again today to call on you with an even greater sense of urgency. Just last year, this Legislature passed what was called the strongest PBM regulation bill in the country. As we know, on December 26th it was vetoed. Now New York remains unprotected from PBM profiteering and lags behind other states who have already begun to crack down on the PBM abuse of patients, of providers, and of taxpayers.

The Executive has proposed a health budget with four parts related to pharmacy. Part G deals with prescription drug pricing and an accountability board. We feel that that could be successful, but only as a complement to strong PBM reform. Without PBM
regulation, this proposal is not able to address the root cause of rising prescription drugs. And additionally, limiting the board's ability to only investigate drugs which have increased by 100 percent, may hinder the board's effectiveness.

Part H of the Executive's proposal deals with expansion of assistance for licensed pharmacists. PSSNY supports this ratio, and as we know, last year New York State expanded the use of unlicensed persons and created a registered pharmacy technician class. The Governor now proposes expanding the pharmacist ratio from four to six, while also clarifying that registered pharmacy technicians can perform additional duties under the supervision of a licensed pharmacist in all practice settings.

PSSNY supports this practice-side parity, but we do have some concerns about the ratio increase from four to six.

Part I deals with pharmacy adult immunization expansion and collaborative drug therapy management. New York is currently
one of four states to restrict the vaccines a pharmacist can provide, and PSSNY supports the expansion of this administration of all CDC-recommended vaccines. We also suggest that the Legislature accept the expansion of CDTM from a demonstration program through teaching hospitals to a program that's available to all of New Yorkers.

Part U. PSSNY would suggest that the Legislature modify the Governor's proposal for PBM regulation. It's a solid foundation for New York State; however, we've been here before. On its own, the proposal is not adequate to fully rein in PBM practices. We feel compelled to reiterate that this Legislature has previously passed what was considered the most robust PBM reform measure in the country.

PSSNY believes that PBM reform must contain clear statutory language that eliminates spread pricing in commercial plans. PBM reform has been discussed by the Executive, DFS, and the Senate for a number of years now. How many pharmacies will have
to close, how many patients will have to be
manipulated, and how much more profit will
New York allow to these Fortune 25
corporations at the expense of its own
constituents?

Thank you for your time.

CHAIRWOMAN WEINSTEIN: Thank you. We
have -- Senator Rivera has a question?

SENATOR RIVERA: Yes, ma'am.

Good evening -- because now it is
actually evening, thank you for sticking
around. So just for the record, have you --
has the Pharmacists Society of the State of
New York been contacted by anyone in the
administration regarding your potential
participation in the MRT process?

MR. MOORE: Yes, we did discuss --

SENATOR RIVERA: Whoa, whoa, hold

it --

MR. MOORE: We did discuss with DOH on
our stakeholder call last week that we feel
that pharmacists should be part of MRT II, we
were left out of the original one, and so
we --
SENATOR RIVERA: Hold on a second.

This is actually very interesting, because I was just waiting for you to answer no and moving on, but -- so did they reach out to you, or you're saying that you have a preset -- like that you were already having a -- going to have a conversation about something else, and then you brought it up?

MR. MOORE: Yes, so we -- as part of our monthly stakeholder calls, we brought it up as part of the agenda. And we were contacted subsequently by DOH for a name, and we provided the name of a PSSNY member who is a community pharmacy owner from the Bronx, Roger Paganelli, who we think --

SENATOR RIVERA: Yes.

MR. MOORE: -- would be a great addition to the --

SENATOR RIVERA: Former president of --

MR. MOORE: Past PSSNY president, yes.

SENATOR RIVERA: So you actually gave them -- so we have, like, one potential person. That's like -- so if it's Roger --
MR. MOORE: He's got --

SENATOR RIVERA: -- and, like, I guess the Governor. So I guess we've got two dudes so far.

MR. MOORE: If anybody could do it, it would be Roger. You know that.

SENATOR RIVERA: No, I know Roger. And Roger's --

MR. MOORE: If anyone could do it, he's the guy.

SENATOR RIVERA: He's a good dude to have in that room.

But I just -- but in all seriousness, if there was at least some level of back and forth -- that they'd -- so they called you and they asked you whether you had a name to suggest.

MR. MOORE: Yes. Like I said, we have a monthly stakeholder call, and after the Governor's budget talk we brought it up on the stakeholder call and we said that pharmacists would like to be included. And they subsequently sent an email asking for names.
SENATOR RIVERA: All righty. I'm hoping that that is actually -- that actually turns into something.

MR. MOORE: Fingers crossed.

SENATOR RIVERA: Yes. Thank you so much for sticking around tonight.

Thank you, Madam Chair.

CHAIRWOMAN WEINSTEIN: Thank you.

We go to Assemblyman Cahill now.

ASSEMBLYMAN CAHILL: Hi, how are you.

MR. MOORE: Good, Assemblyman. How about yourself?

ASSEMBLYMAN CAHILL: A couple of things.

Have you had a chance to look at the Governor's full proposal on pharmacy benefit management regulations this year?

MR. MOORE: We have.

ASSEMBLYMAN CAHILL: And if you could, in just a couple of words, summarize the key points that you think are missing from that proposal.

MR. MOORE: So there's a framework for a solid proposal. We are concerned that the
Governor's proposal deals largely through --
deals with PBMs largely through regulation
rather than statute, where we feel some of
this should be put into statute.

You know, we thought that last year's
piece of legislation was excellent PBM
legislation, so anything that's not quite as
strong and as robust as that piece of
legislation is something that's going to be a
little disappointing.

ASSEMBLYMAN CAHILL: So the question
of regulation versus statute, because of the
uncertainty of regulation, because of the
ability to change regulation, because of the
enforcement ability behind having a
statute -- all those other aspects of it.

And also, you know, as we've heard
from advocates of the Governor's position,
there are many, many legal issues surrounding
this and many litigants surrounding this who
would like to come and litigate every aspect
of it, so regulation could present a problem
in that regard too, right?

MR. MOORE: That's my understanding.
Correct.

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

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

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

And they have an obligation. We as
pharmacists have an obligation, you know,
physicians have an obligation, other
healthcare providers have an obligation. If
the PBMs are going to be involved in the care
to the standard and to the degree to which
they are, they should have an obligation as
well.

ASSEMBLYMAN CAHILL: Now, you run an
independent pharmacy, correct?

MR. MOORE: I do.

ASSEMBLYMAN CAHILL: What percentage
of your business comes through -- filters at
some point through a PBM?

MR. MOORE: Probably about 99 percent
of it.

ASSEMBLYMAN CAHILL: Ninety-nine
percent of your business. So if the PBM
makes a decision and you have no recourse,
you're stuck with it. What does that mean to
your business?

MR. MOORE: It means we close our
doors.

ASSEMBLYMAN CAHILL: Close your doors.

Have there been instances where the
PBM has insisted that you charge a lower price than you paid for a drug?

MR. MOORE: The clawback issue was largely a circumstance of one particular PBM, and we do not have a lot of that particular payer in our area. I have seen it happen, but it was not in my experience.

ASSEMBLYMAN CAHILL: And the membership of your organization has seen it.

MR. MOORE: Yes, I can confirm that it's happened. I did see it happen -- granted, I'm in a small town in upstate New York -- on a limited basis. I did not see it to the same degree that others did.

ASSEMBLYMAN CAHILL: And let's say that something happens midyear where you have been relying upon something that a PBM told you was going to be the rule, and then midyear they change that rule, and maybe they even have the right to do so under a contract that you have with them. But it really does your business a great detriment.

What is your recourse right now if your contract says that's what you've got to
do?

MR. MOORE: We have no recourse for any issue with a PBM at this point.

ASSEMBLYMAN CAHILL: And your customers, the patients who come in and see you, they often present you with an insurance card and oftentimes they have a copayment that is included with the price of -- you know, included with the cost of the drug to them.

If there is a price on that drug -- I only expect a couple of numbers here, we'll forget the dispensing fees and all that. The drug is $15, the copay is $10, and the rebate on that drug that might inure to the benefit of the PBM is $11. Does that customer pay $4 or $5?

MR. MOORE: And so, interestingly enough --

ASSEMBLYMAN CAHILL: Or $10?

MR. MOORE: What the customer pays is now -- it now depends on where they sit in regard to their deductible. We're finding that when a customer is within their
deductible period, they're paying a higher amount for their prescription than the PBM subsequently pays when the patient reaches their deductible and the PBM is responsible for the payment.

ASSEMBLYMAN CAHILL: Right. So again, the statute that Assemblyman Gottfried and Senator Breslin proposed had a duty of care also to the patient. Do you think there's validity to having such a thing?

MR. MOORE: Absolutely.

ASSEMBLYMAN CAHILL: Okay. We have a lot more questions on this, but I thank you for continuing to run a community pharmacy, and I thank you for your answers here today.

MR. MOORE: Thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

Assemblyman Garbarino.

ASSEMBLYMAN GARBARINO: Thank you, Madam Chairwoman.

How are you?

MR. MOORE: Good. How about yourself?

ASSEMBLYMAN GARBARINO: A quick question. You suggest in your testimony that
the Legislature modify the drug accountability board, the proposal. What would you like to see? Like what modifications would you like to see?

MR. MOORE: I guess by "modify" we feel that that's only going to be effective coupled with strong PBM reform. We feel PBMs are still pervasive in the pricing issues that we're experiencing.

You know, when you have Pharma and drug companies talking about how they have to adjust their practices because of the way PBMs structure their rebate programs -- and I'm not absolving Pharma of, you know, pricing issues, but at the same time I just feel that we need robust PBM reform to make sure that that's effective. Much like we need robust PBM reform to make sure that issues like our MAC law are effective, issues like our AMMO law are effective. We know that we pass those and they don't work as intended here in New York.

ASSEMBLYMAN GARBARINO: You think -- you said possibly modifying the 100 percent
increase -- what would you -- is it something
over a couple of years? Is it a lower amount
in one year --

    MR. MOORE: It's probably a
combination of something over a couple years
versus a big increase over a period.
    You know, you can have legitimate
instances -- Hurrican Sandy a few years ago,
where plants were destroyed here in New York,
you know, the price went up. Did the price
have to stay up once the stuff came back on
board and, you know, manufacturing was able
to catch up? Not necessarily.
    You kind of limit yourself with
100 percent, I think, with something like
that.

    ASSEMBLYMAN GARBARINO: Thank you.
    CHAIRWOMAN WEINSTEIN: Thank you for
being here.

    MR. MOORE: Thank you for having us.
    CHAIRWOMAN WEINSTEIN: Next we have
the Pharmaceutical Care Management
Association, Lauren Rowley, vice president,
to be followed by the Community Pharmacy
MS. ROWLEY: Good evening, Chairwoman Weinstein and Chairman Rivera. My name is Lauren Rowley, I'm with the Pharmaceutical Care Management Association. I appreciate very much the opportunity to be here once again before this committee to provide testimony on behalf of the pharmaceutical benefit managers, the PBMs of New York.

PBMs administer prescription drug plans for more than 266 million Americans nationally. In New York, we administer prescription drug plans not just on behalf of health plans, but for hundreds of self-funded unions, school boards, municipalities, and employers across this state.

I think it's important to note that not one of these entities have to hire a PBM. The Medicare did not have to hire a PBM -- Medicaid. This NYSHIP, they do, because we're the one entity in the supply chain that has one job to do, and that is to hold down the cost of prescription drugs.

As the attached article in your
materials show, our ability to provide services effectively has real-life implications for individuals in your communities. PBM management is the difference between unions and school districts being able to manage prescription drug benefits within their budgets or being forced to make difficult choices.

PCMA does not oppose licensure and regulation and certain levels of transparency. In fact, we believe that there should be transparency for all actors in the drug supply chain, including pharmacies, PSAOs, and Pharma. But we also believe very strongly that budget policy decisions should be made on objective data.

For example, the narrative that PBMs are putting independent pharmacists out of business in New York is false, and objective data bears this out. According to independent data from Quest Analytics analyzing NCPDP data, the number of independent pharmacies in New York increased from 2,185 pharmacies in 2010 to 2,813 in
2019. That is a 29 percent increase in the
number of independent pharmacies.

Conversely, chain pharmacies at the
same time in 2010 had 2,079 pharmacies, down
from -- I mean today, I'm sorry, they have
2,079 pharmacies down from -- I mean, up
to -- down from 2,236 pharmacies. So really,
chain pharmacies are going out of business at
a much more rapid rate than independent

pharmacies.

I want to take one second to talk
about PSAOs, because I think one of the
things when you talk about middlemen, it's
always PBMs -- PSAOs are actually the
entities that contract -- 90 percent of the
contracts that are signed by PBMs with
independent pharmacies are done through a
middleman called a PSAO. So they are a very
relevant entity within the chain of drug
supply that have not been discussed.

They're the ones that are tasked with
negotiating contracts with PBMs. In
addition, they're generally wholesalers who
supply the drugs to the independent
Regarding the Medicaid budget deficit, when the pharmacy benefit was carved into managed care under MRT I, PBMs helped save the state and federal government an estimated $200 million per year, according to DOH's estimates.

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

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

CHAIRWOMAN KRUEGER: Senator Rivera.

MS. ROWLEY: Senator Rivera, my answer is no, we have not been contacted to participate. We would welcome the opportunity.
SENATOR RIVERA: I just have to check.

Thank you, Madam Chair.

CHAIRWOMAN KRUEGER: Assemblymember Cahill.

ASSEMBLYMAN CAHILL: Thank you.

Are you glad we didn't do a panel like we did last year?

MS. ROWLEY: I was kind of looking forward to the cagefight again this year.

(Laughter.)

ASSEMBLYMAN CAHILL: We sold tickets last year for it.

A couple of questions, more about how your organization came to advocate for or against the particular form of regulation of PBMs. And last year you issued a memorandum against the Gottfried-Breslin bill. Do you remember when that memo was published?

MS. ROWLEY: I don't recall exactly when that was published.

ASSEMBLYMAN CAHILL: And how do you arrive, in your organization, at your decision to issue a memorandum in support or opposition? Does the staff make that
decision on their own, or do the member
organizations participate in that
decision-making?

MS. ROWLEY: It's done with the
members' participation.

ASSEMBLYMAN CAHILL: And is it a
majority vote? Or different all the time?

MS. ROWLEY: There are also
fundamental things that PCMA stands for with
regard to legislative principles that are
pretty well known.

But yeah, generally speaking, the
actions in the state are driven by its
members.

ASSEMBLYMAN CAHILL: I'm sorry, I lost
you --

MS. ROWLEY: I'm sorry. The actions
of PCMA in the state is driven by its
members.

ASSEMBLYMAN CAHILL: Driven by its
members. And at the time the memo was issued
against the Gottfried-Breslin bill, was
CVS Caremark a member of your organization?

MS. ROWLEY: They were, and they are.
ASSEMBLYMAN CAHILL: And did they participate in the decision-making that led to the decision to oppose the Gottfried-Breslin bill?

MS. ROWLEY: They were unable to do so. PCMA actually represents 18 PBMs. There are 66 PBMs across the country, and we have 18, many of which are represented here in New York.

ASSEMBLYMAN CAHILL: Yeah. So are any members of Caremark serving on your board?

MS. ROWLEY: Yes.

ASSEMBLYMAN CAHILL: Okay. So who is that? In what position?

MS. ROWLEY: John Roberts does -- I'm assuming you're talking about the board of directors of PCMA?

ASSEMBLYMAN CAHILL: Yes.

MS. ROWLEY: Yes. John Roberts from CVS Health.

ASSEMBLYMAN CAHILL: So how did that work? Did CVS recuse -- did they walk away from the discussion? Did they say, We can't take a position? Or did they say, We would
support -- we have to support this, because
that's the commitment we made when we got
permission to combine with Aetna, and we
signed an agreement to that effect?

MS. ROWLEY: I believe CIGNA also did,
and they're also a member of ours. They did
not participate with our other New York
members during our activities here with
regard to the Governor's budget last year.

ASSEMBLYMAN CAHILL: Okay. Well,
thank you very much for that.

You've seen -- and just -- I'm sorry
if I didn't catch it when you testified --
you've seen the Governor's proposal. Is it
something that you are supportive of?

MS. ROWLEY: We have some concerns --
I think the similar concerns that we shared
last year with the wide discretion of the
superintendent in certain areas, especially
the code of conduct areas. So we -- but we
look forward to working through those,
hopefully, with the Legislature and with the
Governor.

ASSEMBLYMAN CAHILL: Mr. Gottfried
couldn't be here, he had another obligation, but I know that he was very concerned in his questioning of a previous witness about the duty-of-care provisions that were included in his bill but are not included in the Governor's bill. And the way he phrased it is: Do you believe that PCMs should have a duty of care to patients? Do you believe that PCMs should have a duty of care to providers?

So what is the position of your organization in that regard?

MS. ROWLEY: So specifically on the fiduciary mandate, we are opposed to that. That's actually been litigated, and we were successful in overturning that in D.C. several years ago, as being preempted by federal law.

We have a concern, we did offer language, you know, good faith and fair dealing with regards to the contracts the PBMs sign with their clients. We are -- the obligation of a PBM is fully laid out within the contract that a PBM has with its
respective clients, so they -- you know, they
can always sue us under a breach of contract,
and we've seen cases where that's --

    ASSEMBLYMAN CAHILL: I only have a
couple of seconds left, and I don't mean to
interrupt you, but you specifically said duty
of care to your clients. But the question
was about duty of care to consumers, to the
public, to patients, and to providers.

    Does your contract specify those
things for those entities?

    MS. ROWLEY: Within the contracts that
we have with our health plans, absolutely.
All of that is laid out, the duty of care
that a PBM must -- you know, performance
guarantees, the adherence, the drug
utilization review, all of the things that a
PBM does.

    Keep in mind that the health plans are
the ones that are collecting the premiums
from the patients. PBMs do not touch the
patients in that way, they administer the
benefit on behalf of the health plans who
administer -- who define the benefit --
ASSEMBLYMAN CAHILL: Well, again, I would have to differ with you a little bit on whether the PBMs have a direct influence and a direct contact with patients. I think they have a very significant and pervasive relationship with patients.

But thank you for your testimony, and I think if it's good enough for your contract, it ought to be good enough for the law.

MS. ROWLEY: And just -- I know you didn't ask it, but you did for somebody else. You asked a question regarding a PBM's obligation to a pharmacy, and those also are driven by the contracts that are signed, which is why I think this legislative body should consider looking at PSAOs.

I think it's a serious issue. We've tried to raise that in other states, and it's -- they're the ones that are actually negotiating the contracts on behalf of the independent pharmacies.

CHAIRWOMAN KRUEGER: Thank you.

Assemblymember Garbarino.
ASSEMBLYMAN GARBARINO: Thank you.

You just started my question. PSAOs, what -- can you get into that? I really don't -- you mentioned them a couple of times, and I'm not really exactly sure --

MS. ROWLEY: They're pharmacy services administrator organizations, and they're paid for by the pharmacists who contract with them.

And basically they're little companies -- not really, they're Fortune 20 companies like AmerisourceBergen, Cardinal Health, and several others. There's also smaller PSAOs that independent pharmacists will contract with.

And their job is to work with the pharmacists to help them with Medicaid and Medicare, their contract obligations. They're the ones that negotiate the contracts on behalf of their clients, so maybe they have 800 independent pharmacies that they work with, that they'll negotiate the contracts with the PBMs.

They also often -- as I mentioned
AmerisourceBergen and Cardinal, they're wholesalers, so they also sell drugs to the pharmacists. We -- PBMs have no visibility whatsoever to the contracts that the PSAO has with their pharmacy clients. Those are obviously proprietary between those two entities, but they're not really looked at. And I think when we're being blamed for all these contracting issues, I think that that's an important element that hasn't been discussed.

ASSEMBLYMAN GARBARINO: So you contract with the PSAO, is that how it works?

MS. ROWLEY: The PSAO will sign a contract on behalf of the independent pharmacist.

CHAIRWOMAN KRUEGER: Okay? Thank you. Assemblymember Byrne.

ASSEMBLYMAN BYRNE: Thank you. I'm looking at this article that you reference in your testimony about the -- I hope I'm pronouncing this right -- the Voorheesville School District. And I'm just trying to follow a little bit, because it
looks like they had a PBM and they still
didn't get savings. Can you just explain
that a little bit --

MS. ROWLEY: Sure.

ASSEMBLYMAN BYRNE: -- about how that
would happen?

MS. ROWLEY: So originally they had
like an open formulary, so they didn't use
PBM tools.

And one of the major reasons PBMs are
utilized is because of being able to use
prior authorization and step therapy and
things that -- controlling costs, and
preferring generic drugs, for instance, over
branded drugs. And then the competition of,
you know, formulary placement and those types
of things.

So when they started using formulary
tools, they actually saw a significant
savings.

ASSEMBLYMAN BYRNE: Okay. Now, you
also mentioned in your testimony here that
PCMA believes that there should be
transparency for all actors in the drug
chain. Now I'm hearing you saying you want transparency -- can you explain a little bit about what you mean within the drug chain, all these other entities, can you elaborate on that a little bit?

MS. ROWLEY: Yeah, I mean, my understanding is that all providers in Medicaid, for instance, have an obligation to report -- to submit cost reports that pharmacies do not.

Transparency exists between PBMs and their clients. Any level of pass-through is -- again, PBMs will bid on contracts with their clients, and if the clients say we want 100 percent pass-through of all rebates, they get that. They can audit the PBM to ensure that they're getting that.

I think that there's some transparency issues relative to Pharma that should be discussed, and of course the PSAOs which I've already mentioned.

ASSEMBLYMAN BYRNE: Okay. Thank you.

CHAIRWOMAN KRUEGER: Okay. Thank you very much for your testimony here tonight.
It's appreciated.

Next we have the Community Pharmacy Association of New York State, Diane Lawatsch -- she will pronounce it correctly when she gets up.

Thank you.

MS. LAWATSCH:  Good evening.

CHAIRWOMAN KRUEGER:  Good evening.

MS. LAWATSCH:  Good evening. My name is Diane Lawatsch, like "watch" --

CHAIRWOMAN KRUEGER:  Thank you.

MS. LAWATSCH:  -- and I am an officer of the Community Pharmacy Association of New York, and I'm a licensed pharmacist at Wegman's Food Market.

Thank you for your strong past support of community pharmacy in New York and for the opportunity to testify today related to the state fiscal year 2020-'21 State Budget. In our written comments that have been submitted, we comment on six Executive Budget proposals. I will briefly summarize the top priority areas today.

First, we are very concerned about the
1 percent across-the-board Medicaid cut
enacted January 1st, along with the
possibility of further cuts as the result of
the proposed MRT II process.

Community pharmacy has seen very
significant cuts over the last several years,
namely due to the move of the state's
Medicaid pharmacy benefit of managed care for
most beneficiaries. Pharmacies are now paid
at or below their actual costs by
managed-care plans and their pharmacy benefit
managers. This model is untenable, and there
is no ability to sustain any further cuts.

In fact, as it relates to all of our
payers -- and speaking on behalf of my
pharmacy -- managed Medicaid is at or below
our cost of dispensing 90 percent of the
time. As a pharmacist for the past 30 years
in New York State, it is incredibly
disheartening to watch this trend.

When discussing the Medicaid
shortfall, the Governor stated that there
should be zero impact to beneficiaries. This
is very important, but it's also critical
that the administration understand that cuts
to services will impact beneficiaries and
cuts to struggling pharmacies will impact
beneficiaries as we work to remain open and
provide high-quality pharmacy services for
our patients.

We're asking for a seat at the table
for MRT II and have made this request of the
administration. We were not approached, but
we have asked. We have also asked that the
state reconsider the 1 percent reduction, and
we ask for your help to prevent any further
cuts to pharmacy care for the patients we
serve.

Secondly, we strongly support the
Executive Budget proposal related to
pharmacist-administered immunizations. Since
2008, pharmacists have been providing
immunizations in New York. The current law
expires this year, and the Executive Budget
makes pharmacist immunization authority
permanent for all CDC-recommended vaccines
for adults.

It is in the best interest of the
state and public health overall to ensure
that patients have seamless access to
vaccinations seven days a week, including
evenings and weekends. Because pharmacists
currently lack the authority to give all
CDC-recommended vaccines for adults,
pharmacists have had to turn patients away.
This includes adults seeking the measles
vaccine last year during the height of the
outbreak in New York.

With vaccines for a patient who needs
and is interested in getting a vaccine, we
strongly urge New York to join nearly all
other states by allowing pharmacists to
administer all adult vaccines and to make
this law permanent in the final budget.

We want to voice our support for
licensing and regulating pharmacy benefit
managers. This action is urgently needed to
protect patients, pharmacies, and other
providers against unfair and in some cases
abusive practices. We are asking for
immediate action to ensure state oversight
over PBMs, and I know my colleagues at PSSNY
have already spoken to you in great detail on this.

Finally, we support the budget proposal to recognize registered pharmacy technicians across pharmacy settings and discuss other ways that pharmacists can add value, improve outcomes, and reduce costs through comprehensive medication management in our written testimony.

Thank you for your consideration of our comments as we work to ensure patient access to high-quality pharmacy and related care throughout the state. Please continue to see us as a resource of any medication or healthcare topic where we can provide assistance.

Thank you.

CHAIRWOMAN KRUEGER: Great. Senate? Assembly?

ASSEMBLYMAN GARBARINO: One more question.

CHAIRWOMAN KRUEGER: Yes.

ASSEMBLYMAN GARBARINO: So I just heard of the PSAOs today for the first time.
So can you explain a little more what that is? Do you use PSAOs?

MS. LAWATSCH: We do not use a PSAO. So a PSAO is typically used by a group of pharmacists, so that they have a representative to be the go-between between the PBM and their group of pharmacies. So that's why groups of independent pharmacies traditionally have that. We do our own contracting and negotiating with the PBMs.

ASSEMBLYMAN GARBARINO: So your people that are part of your organization, they deal directly --

MS. LAWATSCH: People who are -- correct. True statement.

ASSEMBLYMAN GARBARINO: So you don't use PSOAs at all.

MS. LAWATSCH: We do not.

ASSEMBLYMAN GARBARINO: Okay. Thank you.

CHAIRWOMAN KRUEGER: Thank you very much for your joining us tonight.

MS. LAWATSCH: Great. Thank you.
CHAIRWOMAN KRUEGER: Thank you.
Okay, next up -- I think we're done with the pharmacy organizations -- we have the Agencies for Child Therapy Services, Children's Therapy Services, followed by the Children's Defense Fund, followed by Coalition Against Trafficking of Women.
And this is a test: How many of us up here recognize Steve Sanders, previously of the Assembly, previously my -- an overlapping Assembly member of mine in Manhattan?
EXEC. DIR. SANDERS: And the answer to that question is dwindling every year, I've noticed.
(Laughter.)
CHAIRWOMAN WEINSTEIN: It's nothing personal, Steve.
(Laughter.)
MR. SANDERS: I'm delighted to be here again. Thank you very much, Chair Liz Krueger, Chair Gustavo Rivera, and Chair Kevin Cahill and members of the Assembly and the Senate --
CHAIRWOMAN WEINSTEIN: (Loudly
clearing throat.)

MR. SANDERS: As I've been sitting here -- excuse me?

CHAIRWOMAN WEINSTEIN: Hi.

(Laughter.)

MR. SANDERS: Oh, excuse me. Okay,

I'm done.

(Laughter.)

MR. SANDERS: I'm really done now.

(Laughter.)

CHAIRWOMAN KRUEGER: Didn't you overlap with Helene when you were here?

MR. SANDERS: Yes, as a matter of -- yes, we were about 20 feet -- offices separated by about 20 feet. And I actually arrived two years before Helene did, just a little bit before her dad did, and we served together for a couple of years.

I'm really honored to be here again with all of you. And as I was sitting and listening to the testimony, listening to the questions, it struck me that most health-cost questions are complicated, but with Early Intervention -- and that's what I'm here to
talk about for three or four minutes. But
with Early Intervention, the answer is really
simple.

So the Governor in his Executive
presentation correctly identified the
problem. What he said was that the problem
with Early Intervention funding is that
commercial insurance is simply not paying
their fair share. They don't now, they never
have. And to illustrate that point, the
Governor iterated some very interesting
statistics, all of which are true. He
indicated that of the total $700 million of
reimbursement to Early Intervention
providers, commercial insurance pays
2 percent. Of the claims that are submitted
to commercial insurance, they approve
15 percent of the claims and reject
85 percent of the claims.

Contrast that with Medicaid,
government insurance. Medicaid approves
almost 75 percent of the claims, while
commercial insurance is denying about
85 percent of the claims.
So the problem with Early Intervention was clearly identified by the Governor -- the funding with Early Intervention, clearly identified by the Governor, but he doesn't come up with the right answer. The only additional dollars that the Governor recommends in the Article VII language amounts to about $1.6 million when annualized. It's called pay and pursue, which Kevin Cahill had a little dialogue with the commissioner earlier today.

That is not the answer. Everything that this Governor has tried to do -- and he has tried to do interesting things over the years, as have his predecessors, to try to get commercial insurers to pay their fair share. Everything that they have tried to do in the past has failed. Commercial insurers 20 years ago were paying 2 percent of the grand total of $700 million; they're paying 2 percent of the grand total today.

The answer to that funding disparity, which has to be made up -- whatever commercial insurance denies, bear in mind the
state has to pay and the counties have to pay equally, fifty-fifty. So the Assembly and the Senate actually had the answer last year. You put into your one-house budget bills covered lives to include Early Intervention. What's covered lives? It merely is a

an estimate, it's an assessment on the industry as to what the industry should be paying for a particular service. That is the only way, we have learned -- through experience, expensive experience -- that commercial insurance will finally pay their fair share of any health program, in this case the Early Evaluation Program.

So the Governor lays out the problem accurately. You have the answer. You had the answer last year. I urge you to, in your one-house bills, to replicate what you did last year, which is to include Early Intervention under covered lives.

I would just close by saying this. At this moment in time with this budget, when the question of how to find savings in the health-cost area is so prominent, why would
we not want to insist that commercial
insurance pays its fair share and save the
state and counties what would be tens of
millions of dollars each year? I think you
should ponder that question. And as you do,
I think you will come up with the answer you
did last year: Include Early Intervention
under covered lives, save the state and
counties tens of millions of dollars, and
finally have commercial insurers pay their
fair share.

Thank you very much for the
opportunity, I appreciate it.

CHAIRWOMAN WEINSTEIN: Thank you.

MR. SANDERS: Hello, Helene.

(Laughter.)

CHAIRWOMAN KRUEGER: Senators?

Assembly members?

CHAIRWOMAN WEINSTEIN: Assemblyman

Cahill.

ASSEMBLYMAN CAHILL: Steve, I remember
you when you used to have white hair -- wait.

Yeah, you still do.

(Laughter.)
ASSEMBLYMAN CAHILL: One of my concerns with solving this problem is that we might not see you next year in the evening at the budget hearing. But I'm sure you'll find another cause between now and then.

Can you give me some thoughts as to why maybe this is not happening, because it truly seems to most people like a no-brainer. The ones you can say in public.

MR. SANDERS: I -- I cannot. All I can tell you is that there was a mighty effort that was made to reconfigure the reimbursement and the funding system of Early Intervention back in 2013.

I'll just take one moment to remind you what it looked like before 2013. The counties were responsible for paying providers, and it was the counties' responsibility to recover as much money from commercial insurance as they could. The counties hated doing that. Why? Because they couldn't get any money from commercial insurance. So the counties wanted out.

And I can understand why they wanted
out. It was a lot of administrative cost to them, they weren't getting anything back from commercial insurers, and they were paying providers up-front.

So the state decided to hire a fiscal agent who would act as the intermediary between providers and the insurance world, take counties out of the process of doing the billing to commercial insurance, and the hope, the stated hope was that with the professional services of a fiscal agent, that somehow that 2 percent total that commercial insurance was paying of the Early Intervention reimbursement would rise to 4 percent, 5 percent, 8 percent.

It never happened. I can't tell you why. All I can tell you is that I think that at every turn commercial insurance is very, very good at finding ways and excuses not to pay their fair share, certainly of Early Intervention. I'm not going to comment on any other program. But I've seen this now for all the years that I have been executive director of ACTS, and I saw it when I was in
the Legislature. They are very, very adept
at finding ways to evade and avoid their
responsibility.

ASSEMBLYMAN CAHILL: If I can
interrupt you just at that point.

MR. SANDERS: Yes, sir.

ASSEMBLYMAN CAHILL: So if the
insurance industry was willing to sit at the
table -- we heard today that Dr. Zucker is
prepared to sit at the table. You,
representing the providers, would be willing
to sit at the table. The Legislature has
already proposed it once, and we're ready to
propose it again.

Is there anything you see that would
stand in the way of us resolving it between
now and April 1st?

MR. SANDERS: Well, there's no logical
reason, there's no economic reason. It's a
win for the state, it's a win for the
counties, it's a win for providers because
they won't be burdened with this
administrative weight to have to bill
commercial insurance futilely, take weeks and
weeks and weeks to bill them, not to get the
money back, only to see the money being paid
back by -- ultimately by counties in the
state.

So it's a win for providers, it's a
win for the state, it's a win for counties.
And frankly, I think it's not too much to ask
that commercial insurance pay whatever the
Legislature determines ought to be their fair
share.

We're not asking to soak them. This
is not a soak the wealthy, soak the rich.
This is an industry that has a responsibility
to pay their fair share. That's all we ask.

ASSEMBLYMAN CAHILL: And I'm going to
suggest to you that it may also be a win for
the insurance companies, if it turns out that
they can do away with all the rigmarole
surrounding claim denial and processing.

MR. SANDERS: I would agree with that.
They have to adjudicate tens of thousands of
claims every year, and there's an
administrative cost to that for them as well.

So I am left without any answer to
your question as to what logical reason would
exist not to do what seems to be so obvious
to so many people.

ASSEMBLYMAN CAHILL: Your question
answers my question. Thank you.

MR. SANDERS: Thank you all for
listening. I appreciate it.

CHAIRWOMAN KRUEGER: Thank you, Steve.

Nice seeing you.

Next is the Children's Defense Fund,
followed by Coalition Against Trafficking in
Women, followed by New York State Health
Facilities Association.

MR. ANDERSON: Good evening.

CHAIRWOMAN KRUEGER: Good evening.

MR. ANDERSON: My name is Ben
Anderson. I'm the director of poverty and
health policy at the Children's Defense Fund
New York.

The Children's Defense Fund, CDF, is a
children's policy and advocacy organization.
We work nationally and across New York State
on a variety of health issues. Our written
testimony covers many of these issues, but I
want to focus my remarks today on just two of them.

First is the Medicaid global cap. By way of background, Medicaid is the foundation of New York's children's health system. I think as it was mentioned earlier, it serves roughly 50 percent of New York's children -- that's over 2 million children in the state -- and it serves our most vulnerable children, those living in low-income households, children with disabilities, children in foster care who have been abused or neglected.

And I just want to remind folks that Medicaid is an entitlement program that operates on a promise to these children, as well as low-income adults, seniors and individuals with disabilities, that if they have health needs that are covered by the program, that those services will be paid for and they'll be paid for in an amount that will ensure a sufficient number of providers to meet the needs of the beneficiaries.

And the reason why we're here today --
or the reason why we have a hole in the
Medicaid budget, rather, is because we have
imposed a state cap that is operating the
exact same way that a federal block grant or
a per-capita cap would operate. Block grants
and per-capita caps are dangerous financing
mechanisms because they fail to properly
account for demographic changes, like a
surging elderly population. And they also
fail to account for higher costs of care that
are required to meet patient needs. They
also often fail to protect against population
health needs like epidemics or natural
disasters.

So at CDF we don't think anyone should
be surprised that the budget is in the
position that it's in today. And there's no
way to outrun this issue. As long as there
is a cap like the one we have today in place,
we will keep having this conversation over
and over again.

That means, I think, it's time to take
a serious look at the cap. One thing that we
know from the federal caps that have been
proposed is that they simply shift the burden
from the federal government to -- or would
shift the burden from the federal government
to the states, to counties, to beneficiaries,
to providers. And that's exactly what could
happen if the current cap remains in place.

Before I conclude, I also want to
briefly mention lead poisoning prevention.
CDF has been doing work in collaboration with
a number of partners across the state on this
issue. New York has more children with
elevated blood lead levels than any other
state in the U.S. In some parts of New York
City and New York State the rates of
childhood lead exposure are five to six times
higher than Flint, Michigan, at the peak of
its water crisis. And most children in New
York are exposed to lead from lead paint and
its dust in housing.

Programs to find and fix the lead
hazards in housing are woefully underfunded.
That is why, in addition to the $46 million
that is being requested by the counties, we
also support adding an additional $50 million
to find and fix lead hazards in housing, as
well as support primary prevention efforts in
other ways.

Thank you.

CHAIRWOMAN KRUEGER: Thank you.

 Senate, anyone? We're good?

CHAIRWOMAN WEINSTEIN: We're good.

CHAIRWOMAN KRUEGER: Thank you very
much for coming and testifying.

MR. ANDERSON: Thank you.

CHAIRWOMAN KRUEGER: Next up is
Coalition Against Trafficking in Women,
followed by New York State Health Facilities
Association, followed by Primary Care
Development Corporation.

Good evening.

MS. SAVARESE: Good evening,
Chairperson Krueger --

CHAIRWOMAN KRUEGER: We need the mic
close to your mouth.

MS. SAVARESE: I'm sorry.

CHAIRWOMAN KRUEGER: Thank you.

MS. SAVARESE: Good evening,
Chairperson Krueger, Chairperson Weinstein,
members of the Assembly and the Senate.

Thank you very much for having me.

My name is Lynn Savarese. I'm here today on behalf of the Coalition Against Trafficking in Women, and I'm one of more than 100 women's rights leaders who signed a letter to Governor Cuomo last year urging him to oppose the legalization of commercial surrogacy in New York. Sadly, our letter fell on deaf ears.

Since your last legislative session, I have traveled the country interviewing women who have suffered great harm as a result of serving as commercial surrogates. You will hear from some of them soon. The Governor's proposal to legalize commercial surrogacy has numerous failings, only a few of which I have time today to discuss.

The greatest failing of the bill is its lack of protections for women who would serve as commercial surrogates. Nothing in the bill prevents the targeting of vulnerable women in dire need of money who lack the means or the information to properly evaluate
the risks to their health that are inherent
in the surrogacy contracts sanctioned by the
bill.

These contracts are negotiated without
a semblance of equal bargaining power. On
the one hand, you have a young woman, usually
a mother of small children with no more than
a high school education who is in a
precarious financial situation. She has
little if any knowledge of the health risks
involved in a surrogacy pregnancy, which are
far more onerous than those associated with
the traditional pregnancies she may already
have experienced.

The temptation that commercial
surrogacy dangles before such a woman is
overwhelming. A $30,000 payment often
amounts to more than twice her annual income.

On the other side of the contract, you
have wealthy individuals with vastly greater
financial resources who can spend $150,000 or
more to procure a child.

Another failing of this bill is its
disregard for the well-being of surrogate
children. Under New York law, parents seeking to adopt children must undergo rigorous screening and background checks to ensure their fitness. By contrast, the Governor's bill requires no background check or screening of any kind. In fact, nothing in this bill prohibits convicted pedophiles from purchasing surrogate children or wealthy individuals coming from abroad from purchasing a surrogate child or two dozen surrogate children, and then taking them back to his home country.

These are not hypotheticals but actual cases detailed in attachments to my written testimony.

New York State forbids the buying and selling of organs. You rejected the argument that a person has the right, for example, to sell his kidney, even when it was shown that in addition to receiving payment, he might derive personal satisfaction from saving the life of another. You rejected it because human bodies are not to be bought and sold or rented.
Identical arguments are being advanced by the multi-billion-dollar surrogacy industry. But unlike a kidney selling agreement, a commercial surrogacy contract saves no lives and instead puts the lives of the surrogate mother and the children she bears at risk.

Women who agree to be commercial surrogates take on a far greater risk than those faced in traditional pregnancies or other types of in vitro fertilization pregnancies. The required use of donor eggs in surrogacy pregnancies dramatically increases those risks.

I see that I'm running out of time, and it's so -- I so regret it. Reproductive medicine is one of the fastest growing and most lucrative fields of medicine. But just like the tobacco industry, which thwarted research into harms to smokers for decades, fertility experts have refused to conduct research into the health risks for surrogate women and their offspring.

Even if a would-be surrogate was
advised of all, quote, known risks, her
informed consent remains an impossibility
because those risks are unknowable. We know
that surrogate mothers in the United States
have died as a result of dangerous surrogacy
pregnancies, leaving their own young children
motherless.

New York State is the progressive
leader on so many vital public policy issues.
Your strong stance to protect women and
children by outlawing commercial surrogacy
contracts in the early '90s was true
progressive leadership. Undoing that legacy
would be a giant step backwards. I
respectfully urge you to reject Governor
Cuomo's misguided proposal.

CHAIRWOMAN KRUEGER: Questions?
Questions? Okay.
Thank you very much for your
testimony.
MS. SAVARESE: Thank you.
CHAIRWOMAN WEINSTEIN: Thank you for
being here, Lynn.
CHAIRWOMAN KRUEGER: Appreciate it.
Okay, next, the New York State Health Facilities Association.

Good evening.

MR. HANSE: Good evening.

MS. PAPPALARDI: Good evening.

MR. HANSE: My name is Stephen Hanse, and I have the privilege of serving as president and CEO of the New York State Health Facilities Association and the New York State Center for Assisted Living. Joining me this evening is Jackie Pappalardi. Jackie serves as our executive director of the foundation for Quality Care, our education arm of NYSHFA/NYSCAL.

NYSHFA/NYSCAL is a statewide organization representing over 400 proprietary, not-for-profit and government-sponsored nursing homes and assisted living facilities throughout the state.

I believe that we would all agree that a fundamental role of government is to care for those who are unable to care for themselves, and nowhere is this fundamental
role more evident than in Medicaid's
commitment to our elderly and frail
New Yorkers residing in nursing homes and
assisted-living facilities. This is a
commitment that New York has honored since
Medicaid was first established in 1965.

However, over the last 11 years, this
commitment has wavered, with the state
cutting nearly 1.9 billion from nursing
homes. At $55 per patient per day, New York
now unfortunately leads the nation with the
largest shortfall between the amount Medicaid
reimburses providers for care in a nursing
home and the actual cost of care.

And the most recent data shows that
the average operating margin for New York's
nursing homes was minus 1.3 percent, and
approximately 41 percent of New York's
nursing homes are operating at a loss.

Moreover, the state recently imposed a
1 percent across-the-board Medicaid cut,
directly impacting nursing homes and
assisted-living providers.

However, as we have heard today, when
we talk about long-term care, it's important
to recognize that nursing homes and
assisted-living providers and their
utilization is not what is driving the
Medicaid deficit. It is clear in the
Executive Budget documents that the shortfall
is not a result of institutional long-term
care. This is the case notwithstanding the
fact that nursing homes are caring for an
ever-increasing polychronic, high-acuity
population.

New York is also facing a healthcare
workforce crisis. As Assemblywoman Gunther
stated earlier today, nurses are the backbone
of healthcare. And as you also heard
earlier, 80 percent of nursing home costs are
directly attributable to employee wages and
benefits, and many of our employees are
represented by organized labor.

Given New York's nation-leading
insufficient Medicaid reimbursement rate,
nursing homes and assisted-living providers
are unable to compete with other healthcare
providers in their ability to recruit and
retain nursing staff.

Commissioner Zucker referenced earlier New York's ever-increasing aging population and that nursing home issues are very different now, and those who represent nursing homes and assisted-living providers will be included in MRT II. This is in contrast to the first MRT, on which nursing homes and assisted-living providers were not represented as stakeholders and, as such, were subjected to almost $800 million in direct cuts.

It is critical that nursing homes and assisted-living providers be represented as stakeholders on the MRT II.

In addition to our request to participate as stakeholders on the MRT II, NYSHFA and NYSCAL support strengthening administrative resources and efficiencies at the local government level to support the state's Medicaid program. Many nursing homes throughout the state are facing significant delays in the processing of Medicaid eligibility applications at local DSS
offices. For example, in Erie County alone, providers are owed over $16 million as a consequence of pending Medicaid applications.

NYSHFA/NYSCAL also supports maximizing the state's savings that will be achieved by moving long-term-care nursing home residents from managed-long-term care back to fee for service.

NYSHFA/NYSCAL also supports increasing the ALP reimbursement rate and requests that the state work in partnership with assisted-living providers to provide care for New York's growing homeless population.

As always, NYSHFA/NYSCAL looks forward to continuing to work in partnership with the Legislature, the Executive and all providers to strengthen the state's fundamental role in providing care to New York's elderly and frail women and men in nursing homes and assisted-living facilities throughout the state.

Thank you very much for your time and consideration.

CHAIRWOMAN KRUEGER: Thank you.
Questions? Senator Rivera.

MR. HANSE: Senator, we have not been requested to serve on the MRT II. We would welcome the opportunity to serve.

CHAIRWOMAN WEINSTEIN: Assemblyman Ra.

ASSEMBLYMAN RA: Thank you. Thank you for your patience today.

I just wanted to get -- if you can elaborate a little bit more about the Certificate of Need surcharge and how it would impact your members and their ability to construct new facilities and make sure they have adequate facilities. As you mentioned, you know, the population has different needs than maybe they did long ago, and part of that is always changing facilities to make sure the facilities are able to meet those needs.

MR. HANSE: Sure. NYSHFA/NYSCAL opposes the proposal in the budget to impose CON fees. This is really founded in the fact that New York's nursing home buildings are primarily all -- have all been built in the 1960s and the early 1970s. The age of those
facilities is getting very old. Many
providers are submitting applications for
CONs to update their facilities.

I think the state's first brand-new
nursing home in I think at least nine years
was just opened in White Plains, and it is
beautiful. If you went there, you would
think it was a hotel.

So anything that would impede the
ability of providers to either update their
facilities or construct new ones, we would
oppose.

ASSEMBLYMAN RA: Thank you.

CHAIRWOMAN KRUEGER: Thank you. Thank
you for being here tonight.

MR. HANSE: Thank you very much.

CHAIRWOMAN KRUEGER: Have a good
evening.

Next we have the Primary Care
Development Corporation, Mary Ford. And
getting up on deck, next will be the American
Cancer Society and then the New York State
Vapor Association.

Good evening.
MS. FORD: Good evening. Thank you for the opportunity to testify before the committee today. I'm Mary Ford. I'm the director of evaluation and analytics with the Primary Care Development Corporation, or PCDC. We are a New York-based nonprofit organization and a U.S. Treasury-certified community development financial institution dedicated to building excellence and equity in primary care.

Over the last 27 years, PCDC has worked with over 950 healthcare sites in the Empire State, including seven DSRIP performing provider systems in all corners of the state. And thanks in part to the New York State Legislature, we've financed and enhanced healthcare facilities and practices in the large majority of the State Senate districts and Assembly districts, all in order to improve the delivery of primary care and other vital health services for millions of New Yorkers.

The Executive Budget that we're responding to calls for the formation of a
new Medicaid Redesign Team tasked with an ambitious April 1st deadline to identify $2.5 billion in savings. While we're heartened by the budget's directive that the gap-closing savings will be achieved with zero impact to beneficiaries, we are deeply concerned that the cuts that will be made will compromise New York's primary care safety net.

As you've all heard before, overall less than 10 percent of DSRIP funding went to primary care, behavioral health and community-based social services combined, even though these are the organizations that provide direct services to patients and have the greatest ability to provide these safety net interventions.

We realize that many delivery system reform efforts are underway, but all of these initiatives rely very heavily on primary care to deliver better health outcomes and to lower costs, but they do not provide the full and necessary support to ensure success. There's been drastic underinvestment in
primary care, which drives providers to chase
after every dollar rather than focusing on
the whole person and patient-centered care.

We can't cut our way out of the
Medicaid deficit, especially not by cutting
primary care systems and community-based
health providers. Rather, we must invest
deeply in primary care to see both the health
improvements and fiscal stability that
New Yorkers deserve.

PCDC believes that New York should be
a national leader in its commitment to
funding a strong primary care system.
However, we currently don't even know how
much of New York State's budget we actually
spend on primary care costs of both public
and private payers. There are other states,
I think about 10 to date, that are measuring
primary care spend across payers, all with
the goal of then increasing the proportion of
the healthcare dollar that goes to primary
care.

We urge the Legislature to measure and
increase the proportion of New York State
healthcare dollars that are spent on primary care.

We also support the maintenance of the Patient-Centered Medical Home program. For many years New York State Medicaid has emphasized the PCMH model as a mechanism to support integrated and value-based care. Primary care provider organizations have made extensive commitments to the PCMH practice transformation journey, knowing and believing that there would be incentive payments from the Medicaid program to help support the continued stability of this program. And numerous studies show that the longer a practice is engaged with PCMH, the overall impact of lowered costs and increased outcomes increase.

So there's already been cuts to the per-member per-month payments for PCMH, and so we urge that funding and investments do not be cut further, and continue to work closely with the Health Department to ensure that Medicaid reimbursement and waiver funds are spent as close to the primary care system
as possible.

In addition, the Governor's budget calls for a 3 percent surcharge on all Certificate of Need applications for capital projects. PCDC believes this tax should not apply to community-based providers and small projects, as this presents one more financial barrier to important healthcare facility expansions in low-income communities.

Specifically, small community-based providers can't afford this additional tax. They operate with very thin margins and face potential cutbacks in funding.

And then, lastly, we say again we thank the Legislature for your continued support of PCDC, and we hope that you will do so again in the upcoming budget year. Last year the allocation to PCDC allowed us to carry out our critical mission in evaluating primary care access across New York State and strengthening the primary care sector by promoting strategies for interdisciplinary care.

So again, we thank you for your time
and consideration of PCDC's recommendations.

CHAIRWOMAN KRUEGER: Thank you.

Senate? Well, I actually have one question.

So for years you've been up here talking about how DSRIP didn't really go to the right places. And I've been asking during the day if anyone else saw something in the budget leading them to believe that we're going to sweep DSRIP funds, even from previous years.

Is your group aware of this in any way?

MS. FORD: To sweep? I'm not --

CHAIRWOMAN KRUEGER: To sweep the -- the feds still owe us money for the last three years. People were spending it in hopes they'd actually get it, but you're not going to get it because there's -- the Governor is going to sweep it if it comes in.

Have you been told this?

MS. FORD: I have not been told this. I'm not sure if anyone at our organization has more information. But I'd be happy to get back to you with anything that we're
aware of.

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

MS. FORD: Thank you.

CHAIRWOMAN KRUEGER: All right, thank you very much.

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

MS. HART: Hi, everybody.

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

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

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

So we estimate for 2020 there will be
approximately 117,000 new cancers diagnosed,
and a little under 35,000 people will lose
their lives to cancer. We've also broken
this down by type as well, so breast cancer
remains the most commonly diagnosed cancer,
and right now lung cancer remains the
deadliest cancer in New York State.

We do know that screening is a
critical component to reduce these numbers.
We are fortunate that the state does have a
strong Cancer Services Program, which does
screen for breast, cervical and colorectal
cancer. Now, unfortunately, that program was
substantially cut a few years back by
$5.4 million. You can see, if you look on
page 2, the number of services that have been
provided in the past year, and it includes
over 40,000 breast cancer screening services.

So there still is a huge need for this
program. Even though we've reduced the
number of uninsured, we still have a number
of men and women that rely on the Cancer
Services Program for a life-saving cancer
screening.
In addition to that, the department also funds what's referred to as the Cancer Prevention and Action Program. And this program is funded, but unfortunately only in 12 counties right now. One of their charges is HPV vaccine education. The HPV vaccine, make no doubt about it, it is a cancer vaccine. It can help prevent six types of cancers. If the HPV vaccine were administered to all, we could virtually eliminate cervical cancer, that's how important it is.

The good news, if you look -- I believe it's on page 3 -- you can see the completion rates for New York State, and those numbers have increased. So we have now about 57 percent of kids in the target age have been vaccinated and have completed their vaccination, I should say. It's a two-dose series as well.

But unfortunately, again, this program is only right now offered in 12 different counties, so there's a huge gap there.

Now, when it comes to tobacco control,
you'll see on pages 4 and 5 we have breakdown
of youth tobacco use, some trends that we're
seeing over the past few years, and also who
is still smoking in New York State is on
page 5.

So while there's some encouraging
steps in the Governor's budget, there's a lot
of different proposals there, we think it's
really important that we make sure that we
focus on the most effective interventions.
That has to include money for the state's
tobacco control program, given the huge surge
of kids that we have seen that are now
addicted to nicotine. E-cigarettes are a
tobacco product. FDA regulates them as a
tobacco product. We need to invest more in
the tobacco control program to help those
kids.

Now, the Governor's proposal does
include a restriction for flavored tobacco
products -- excuse me, for flavored
e-cigarettes. We think it's critical that
that applies to all products. We don't want
to drive kids from e-cigarettes to other
flavored tobacco products. So it has to be comprehensive.

It also needs to include menthol cigarettes. Most people don't realize that youth smokers are the most likely to use menthol cigarettes. That's because menthol, similar to when you have a cough drop, where it's soothing, that's what menthol does in tobacco. It soothes and it suppresses coughs, so it's designed as a starter product, and it is most frequently used by kids.

Now, in addition, you may hear claims from the opposition saying, You know what, adults need flavored vaping to quit. But the numbers don't show that. Thirty-seven percent of New York State high school kids are using e-cigarettes. For adults, that number is actually below 6 percent, and half of them are still smoking. So it means they're not quitting, they're dual users.

And then lastly, I just want to touch on one of the recommendations we have in here is a cigarette tax increase. We've heard a lot of talk about the need for revenue, which
certainly there is a need for revenue. If you raised the cigarette tax by $1 -- which is justified because we have not had a cigarette tax increase in 10 years. Our tax is stale. We desperately need it -- it would generate $30.4 million. And it's estimated that over 61,000 New Yorkers would quit. So there's a huge public health benefit. So strongly encourage you to take a look, and there's a summary on the back page of all our recommendations.

Just in the nick of time.

CHAIRWOMAN KRUEGER: Assembly?

CHAIRWOMAN WEINSTEIN: Assemblyman Ra.

ASSEMBLYMAN RA: Thank you.

I just had a couple of quick questions. With regard to the e-cigarettes and other youth smoking, I know that, you know, for years you guys advocated for and now were successful with Tobacco 21, which I supported.

And, you know, I've been reading some data with regard to kids oftentimes getting those products from -- you know, maybe they
have a 19-year-old friend or somebody's older
brother or something like that. You know,
somebody within their social circle. And
that a lot of them would get those types of
products.

So what kind of impact do you think
Tobacco 21 is having and will have on maybe
cutting into some of that teen smoking?

MS. HART: When we looked at
Tobacco 21 evidence, it was estimated that it
would reduce youth smoking by 12 percent.
Now, where it's going to have the biggest
impact is those that haven't already started
on a tobacco product. So it will take some
years for that 12 percent reduction to
actually come to fruition.

ASSEMBLYMAN RA: And then the other
thing is the -- I mean, every year I look at
these and I was looking at this data again in
the fall. The fact that we talk about these
issues and have -- we are so low below where
the CDC says we should be in terms of our
spending --

MS. HART: In terms of funding, yes.
The CDC recommendation is 203 million, and we're at 39 million.

ASSEMBLYMAN RA: I mean, I would assume that could have a great impact too on, you know, counteracting advertising that's targeted towards young people, educating them about the impacts of using these products. I think getting up to that or somewhere in the vicinity -- and, you know, I applaud you for pushing for a multiyear effort to get us there.

MS. HART: Absolutely. It's critical that we don't replace funding with policy pieces. They can supplement, but we have to increase funding.

ASSEMBLYMAN RA: Thank you.

MS. HART: Thank you.

CHAIRWOMAN WEINSTEIN: Assemblyman Byrne.

ASSEMBLYMAN BYRNE: Thank you.

Hey, Julie. I just wanted to -- one of the counterarguments that we hear a lot is about the black market. So if we're going to consider a prohibition on flavored products,
the thought is people will still be able to
access them from other states or potentially
from the black market. And with people
accessing black market vape products, we've
seen a lot of concerns with that.

How would you respond to those
counterarguments and -- as far as prohibition
on the flavors?

MS. HART: Certainly we would like to
see that addressed as well, and we are in
agreement. We do know Massachusetts just
implemented a full ban -- it includes all
tobacco products, including menthol
cigarettes. So certainly we also need to
look at online sales as well.

ASSEMBLYMAN BYRNE: Thank you.

CHAIRWOMAN KRUEGER: Thank you very
much. Appreciate it.

Next we have the New York State Vapor
Association. Then Alzheimer's Association,
then Housing Works.

MS. BABAIAN: Hi. Thank you for
having us here today. My name is Spike
Babaian. I am the technical analysis
director for New York State Vapor Association. We represent 700 mom-and-pop vape shops, small businesses around the State of New York. We do not take funding from Big Tobacco, Big Pharma, or any other large corporations.

The last couple of months we've heard a lot about illnesses and deaths. And the FDA, the CDC and the New York State Department of Health -- actually, first the New York State Department of Health -- confirmed that tainted cannabis cartridges causes the lung illness and death that happened last year. Yet we're continuing to push a flavor ban that has nothing to do with youths getting sick or dying, but does have to do with reducing youth use.

We understand that. But a flavor ban will eliminate 95 percent of e-cigarettes currently sold. It eliminates a billion-dollar industry, decimates hundreds of small businesses, costs thousands of jobs, adds flavored nicotine to an untaxed underground market where no one checks
I.D. -- on the street, no one checks children's I.D.

It also has no regulation, which by the way is how all of those people got sick last year, because there was no regulation of cannabis, because it was illegal. If we make the product illegal, there's no regulation.

National data shows 77.7 percent of youth are not using e-cigarettes for the flavor. This is 2019 National Youth Tobacco Survey data. I'm sure that you have heard a high percentage of youth are using it for the flavor, but 77 percent are not using it for the flavor. So we're not sure where the other data may be coming from. It looks like 2013 data, which was before the high-nicotine pod systems came out.

Hundreds of studies, esteemed researchers, nicotine and tobacco doctors, harm reduction experts with decades of experience, the CDC, the Surgeon General and the FDA all agree vapor products have the potential to reduce smoking and to reduce death and disease from smoking. Yet the
New York State Budget says that banning
e-cigarettes is going to prevent death and
disease and save New York billions of dollars
in Medicaid costs.

If we take away the product that keeps
people from smoking, how is that going to
reduce Medicaid costs? If they go back to
smoking, that increases Medicaid costs -- not
by a little bit, by a lot.

A new study that came out on Monday
provides us with a better understanding of
the youth vaping patterns. It's critical for
us to understand this when making policies.

Dr. David Abrams from NYU School of
Global Public Health said, "Reacting too
quickly to reports of youth vaping without
considering the full context could do more
harm than good. We need to avoid
prohibitionist regulations like banning
e-cigarettes while leaving the much more
deadly cigarettes and cigars in corners
stores. Instead, we should consider strong
enforcement of age 21 sales restrictions.

Prohibition creates a black market for vaping
products or inadvertently pushes individuals back to smoking." 

Cheryl?

MS. RICHTER: So hi, I'm Cheryl Richter, I'm the executive director.

The unintended consequences of a flavor ban means a billion-dollar market will immediately go underground. Consumer choices after a flavor ban are to buy it on the street with no FDA regulation, no ISO lab standards, no IDing, no licensing, no taxes. Or they could buy it online and skirt the tax. Or they could make it themselves, which is easy to do and easy to get very wrong. Or they can return to smoking.

Not to mention the severe consequences to New York -- thousands on unemployment payments, hundreds of millions in taxes lost, billions in increased costs to Medicaid when people return to smoking.

There are numerous state and federal laws that just went into effect that will help curb youth vaping. A New York Supreme Court judge cautioned the Legislature to give
these laws time to be effective.

As of next week, FDA removes from the market the small high-nicotine flavored e-cigarettes, other than tobacco and menthol. They are banning the devices that they have determined, by looking at the data, to be the preferred product of youth -- the ones that looks like the thumb drives, for the most part.

We've repeatedly recommended regulations to curb youth use, including employee training, I.D. scanners, marketing, display and packaging restrictions, and online age verification. We suggest a compromise, a liquor store model that allows tobacco and menthol flavors where deadly cigarettes are sold, but restricts other flavors to age-restricted environments.

MS. BABAIAN: We had a bunch of comments on the budget, but as we're out of time -- we had specific comments on parts of the budget, but they are included in our testimony.

So if anyone has questions, we're
happy to answer them.

CHAIRWOMAN KRUEGER: Senators?

Assembly.

CHAIRWOMAN WEINSTEIN: Assemblyman Garbarino.

ASSEMBLYMAN GARBARINO: Just one quick question. I'm not in favor of the total flavor ban. I think if we can have something called -- we have flavored alcohol -- cherry, pineapple. But one of the things that people talk about is how many kids are using it. Would you agree it might help the industry if they got rid of certain names, you know, like Unicorn Milk or all these other --

MS. RICHTER: We agree with certain marketing restrictions. And over the years, where we have been trying to bring about a lot of change with, you know, childlike-looking things, the FDA has finally started really regulating those kinds of images and names and that kind of thing.

ASSEMBLYMAN GARBARINO: Okay. Thank you.
CHAIRWOMAN WEINSTEIN: Assemblyman Byrne.

ASSEMBLYMAN BYRNE: I want to thank you for being here as well.

A similar question to the speaker who just asked before. If we're going to ban flavors for a vape product, a concern -- I know you've already expressed in your testimony that it could go underground. I'm taking that as going to the growing black market, where we have already seen that people have had access to some of these devices where they've had harmful chemicals in them and it's caused fatal issues where people have actually lost their lives and gotten really, really ill.

I also wanted to just confirm something, because your comments in answering the question from my colleague Mr. Garbarino about the marketing -- I think I showed you some of the pictures in my district. There is a vape shop in the hamlet of Carmel in Putnam County right next to a public library, and they have posters that take up the entire
space of the storefront window. And on those
posters there's a picture of -- it looks like
four or five 20-year-olds. So it clearly is
marketing to young people.

To me, that's like a pretty clear
argument not -- it's not necessarily the
flavors, but restrictions on things like
that, rolling things like that back and
controlling that, those are restrictions that
you would be in favor of?

MS. RICHTER: Yes.

MS. BABAIAN: Mm-hmm. We've
encouraged those, you know, year after year,
and somehow they don't ever seem to be -- get
passed.

ASSEMBLYMAN BYRNE: Okay, thank you.

CHAIRWOMAN KRUEGER: Just for the
record, I don't have my colleagues here
tonight, and I'm just too tired to have the
argument tonight. But I actually think we
should try to do everything imaginable to
stop young people from using these products
in any way. Just to go on record.

Now I'm going to ask you to leave.
Thank you very much for being here tonight.

MS. BABAIAH: Thank you so much for your time. I just hope that people will consider we can't undo this once it's done.


I would also like to make that illegal. Is the Alzheimer's Association still here? No? Anybody want to rep Alzheimer's tonight?

Okay, let's just make it illegal. Thank you.

Housing Works is next, followed by the Sickle Cell Thalassemia Patient's Network.

MR. KING: Charles King, CEO of Housing Works, also representing some 90 organizations through our members of the Ending the Epidemic Coalition.

I want you all to know I was thrilled when I came in and saw how far up the list I had moved after --

(Laughter.)

MR. KING: -- closing you all out the last two years in a row. And I believe I'm actually testifying the latest I've ever testified in front of you all. So I
congratulate you on your endurance.

SENATOR RIVERA: The earliest.

Earliest.

CHAIRWOMAN KRUEGER: Earliest, you meant.

MR. KING: I'm sorry?

SENATOR RIVERA: The earliest.

MR. KING: No, I actually -- I think I've testified earlier than this before. So I congratulate you on your endurance.

So look, this is 2020. This is the year we're supposed to be ending the epidemic, under the Governor's plan. And we're also supposed to be launching an effort to eliminate hepatitis C as well as addressing the opioid epidemic.

But the reality is that the Governor's Executive Budget doesn't rise to this historic moment. And in fact, not only do his proposals fall dangerously short of concrete commitments to achieve these goals, at the same time he is undermining the Medicaid program and the overall health and well-being of the most vulnerable
New Yorkers.

Now, I want to speak first to the Medicaid proposed cuts and MRT process. I'm not at all opposed to the MRT process. I was very suspicious of it the first round, and railed against the first set of things that came out of it, but Housing Works submitted 17 proposals and 12 of them were ultimately implemented. So I think the MRT process, properly done, can be successful.

But I want to point out that the MRT process in its first round last time was done before the budget was passed, and the Legislature had the opportunity to fully consider everything that was in it. And it should be done exactly that way once again.

I would also point out that there's considerable bad faith when in the Governor's Budget there are these shocking cuts to the MRT-related housing investment that could put more than 5,600 households homeless. And I know, Senator Krueger, you referenced that earlier in your questions this morning.

But that actually gives me an
opportunity to address Senator Rivera's question about the cap. Absolutely, the cap needs to be reconsidered. It was an artifice. And I want to recall the promise of the cap. The cap was an artifice that contained spending. And great, it worked for several years. It didn't get raised as it should have been.

But the promise of the cap was if you did savings under the cap, those savings would get reinvested in social determinants that would improve health outcomes and further drive down the cost of healthcare. And the Governor followed through on that for the first two years, and then Year 3 the Division of the Budget started clawing that money, and they have never lived up to the promise of savings under the global cap being reinvested.

So how dare they now say we're over the global cap? And how dare they cut housing for people who are some of the most frail New Yorkers and potentially risk making them homeless?
I also want to stress that there's another issue with this whole process. First of all, last year we had -- not last year, last time round, we had an innovator in the person of Jason Helgerson, who was really driving this process and looking for good outcomes.

The Division of the Budget has been meeting with folk in DOH and the second floor every Thursday for the last several months to line up exactly what is going to be put before this MRT. So the fact of the matter is, this isn't being driven by an innovator who's looking to improve health outcomes, this is being driven by the New York State Budget Director, who's also already been proven to be more interested in slashing state expenditures in the short term, even at the risk of public health.

Further, as was the case with the first time, this process is going to be very strongly influenced by the hospitals, nursing home industry, and their allied unions, who will have the strongest voices -- when in
fact transformation of those very industries
is what we need if we really want to
right-size our healthcare in New York.

That would mean transitioning to
community health services as the primary
focus of care, closing unnecessary beds,
closing failing hospitals where there are
alternatives for care, and elimination of
redundant expensive equipment and procedures
that drive the most profitable hospital
revenues.

So just to quickly go to the other
areas of the budget, because I don't want to
ignore them, once again we see Article VI
cuts, particularly imposed on New York City
but also imposed on other localities. This
funds basic public health. We can't allow
that to happen.

And we're very concerned about what's
going to happen with the healthcare program
under the MRT process. And also, once again,
the Governor has failed to live up to his
promise around overdose prevention centers.
And the rest is all in my testimony.
CHAIRWOMAN KRUEGER: Any questions?

Senator Rivera.

SENATOR RIVERA: Thank you for hanging out for as long as you have, sir.

So I wanted to get back to talking to you about what you were talking about, the MRT. Specifically, you did say that you railed against the first process but eventually became a believer in it. And then you -- at the end of the time when you were talking about it just now, you did say that you believed that this could be successful if it's done the same way.

We have to acknowledge that it has not been done the same way. Because again, I was pointing out this morning, it is January 29th -- it technically still is January 29th, although who knows, it might get to midnight. But it's January 29th and we don't have any information.

On January 29th of 2011, we already had the MRT that had been put into place, they had already -- the membership was already established, there might have already
been meetings, there were already
conversations. Here we are on January 29th,
we don't even know who's in it.

So at least you can acknowledge that
it has not been -- that it has not been
carried out the same way.

MR. KING: I thought you were going to
ask if I'd been asked. I was going to say,
you see how far I fell on the
{unintelligible} list --

SENATOR RIVERA: Charles, see, now
you -- Charles, you're ruining my bit. That
was supposed to be the second question,
because everybody expected for it to be the
first one.

But anyway, answer the first
questions, then we'll get to that one. So do
you believe, as far as the process right
now --

MR. KING: No, I -- I think I was
trying to indicate I believe that this
process is already completely rigged, and
it's up to the Legislature to stop this
process and put a more sensible process in
By the way, you didn't ask me, but in my testimony we do support and are happy to stand here and tell you that we support raising taxes on the wealthy, raising taxes -- putting taxes on second homes, all the rest of that good stuff. It's not a lack of revenue or resources, it's lack of political will.

SENATOR RIVERA: That was going to be my third one, but you answered that one. And so you haven't been asked to be on?

MR. KING: I'm sorry. I'm sorry.

SENATOR RIVERA: I'm going to find one person, I swear. I'm going to find one person. Thanks a lot, Charles.

Thank you, Madam Chair.

CHAIRWOMAN KRUEGER: Thank you. Thank you very much, Charles.

MR. KING: Certainly.

CHAIRWOMAN KRUEGER: Okay. Sickle Cell Thalos -- Thalasom -- oh, just say it when you get up here so then I don't keep
embarrassing myself.

MR. MOULTON: Hi. It's Sickle Cell Thalassemia Patient's Network.

CHAIRWOMAN KRUEGER: Of course. Thank you. Welcome.

MR. MOULTON: Hi, I'm Thomas Moulton. I'm a pediatric hematologist, and I have treated sickle cell disease patients for approximately 30 years. I am part of the board of SCTPN, which is easier to say than Sickle Cell Thalassemia Patient's Network.

And I also am kind of a de facto coordinator for sickle cell groups throughout the state to promote the sickle cell bill that is now in its ninth or maybe even tenth year that it's here and still has not been passed or funded. And it is Assembly Bill 6493 and Senate Bill 2281.

New York State is the second most populous state with sickle cell disease and has 10 percent of the nation's sickle cell disease population. The median survival of severe sickle cell disease is 38 for men and 42 for women. However, 95 percent of
children will live to the age of 18. Which means that 45 percent of deaths will occur in a 20-year period between ages 18 and 38. Let me repeat that. Forty-five percent of the deaths from sickle cell disease occurs in the adult years -- young adult years -- between 18 and 38.

So it was stated before that people with -- from overdoses are dying because funding isn't there. For 10 years, there's been no funding for sickle cell disease, essentially, from this Legislature and from the Governor. So the Governor has just as much responsibility in it.

It is the largest healthcare disparity, as many if not most of the adult sickle cell patients have no medical home and really only use the ER for care. Other states with fewer sickle cell disease patients provide more funding for sickle cell disease. California just passed 15 million, 15 million for five hub-and-spoke programs. North Carolina has 4 million. While New York State has cut funding for sickle cell disease
over the last 20 years by 66 percent -- a 66 percent cut in funding -- and only has $170,000 in the budget for it.

And so somebody else talked about racism in our budget. Hello, can you spell racism? I spell it as sickle cell disease. And one wonders -- so, Senator Rivera, you were complaining about a possible cut of I think it's $380,000 to 70 patients for cystic fibrosis. There are 8,000 to 10,000 sickle cell disease patients in New York State, and we spend $170,000 on them.

So clearly -- and it's clearly shown in the literature that comprehensive care for sickle cell disease improves care and cuts costs. In 1995, Montefiore Hospital showed that day hospital saved $3 million over a five-year period of time. With the increase in healthcare over the last 25 years, that has to have at least doubled in this.

However, Montefiore then cut that program as soon as the federal funding for that program went, despite the cry out from the patients that were Montefiore-served.
And most -- up to 80 percent of sickle cell disease patients are on Medicaid, with just approximately a 3.3 percent decrease in cost to New York's Medicaid, they can save up to $4 million to $5 million a year.

So in this time where we're saying, oh, Medicaid costs too much, here is a plan that we've told for the last 10 years can save you money, and nothing has been done about it.

So we have been -- so the sickle cell community has been blessed in terms of last year we received funding from the Assembly, increased funding for one year only.

However, the Department of Health took eight months to be able to notify five programs that they already had programs in it that they would receive the money, and then told them they needed to spend the money in three months.

And the Senate then also provided extra funding to community-based organizations in June of last year. To date, SCTPN has not received one dime of that
money, and now are told that they need to spend that money by March 31st of this year. So less than two months to try and spend the money.

Try and have improvement of care when money that you're allocated is not given to you until two months towards the end of the time for it.

The sickle cell bill would allocate $3 million to fund eight comprehensive sickle cell centers throughout the state, and one coordinating center. This will allow for increased access to care and improved care and create statistics on sickle cell disease, including costs of care, for which there are no statistics on sickle cell disease done by the Department of Health.

Thank you.

CHAIRWOMAN KRUEGER: Any questions? We're going to follow up, because the state is famous for taking eight, 10 months to start funding, specifically when it comes from members' items of the Legislature. But they've never had it that it has to be spent
in two months. So we're checking and
following up with you --

MR. MOULTON: They have received
letters --

CHAIRWOMAN KRUEGER: I don't think
that's correct.

MR. MOULTON: -- stating that the
funding must be spent by March 31st.

CHAIRWOMAN KRUEGER: That has not been
the history.

MR. MOULTON: And I must thank your
office, because you helped SCTPN actually
find out who were the sponsors from the
Senate for it, and it helped to try and
figure out how to do and where the money is,
along with Senator Gianaris.

But they still could not figure out
how to be able to get the money, and they
never received a letter from the Department
of Health that they received the money.

CHAIRWOMAN KRUEGER: So we're going to
be following up with you.

MR. MOULTON: Thank you.

CHAIRWOMAN KRUEGER: And I cut you
off, Senator Rivera, I'm sorry.

Anyone in the Assembly?

Thank you for staying so late for us.

MR. MOULTON: I hope you'll give us

the $3 million to rectify it.

(Laughter.)

CHAIRWOMAN KRUEGER: Thank you.

Okay, now we have the Home Care

Association of New York State.

We started with a longer list, but we

might be down to one rep, which is fine. One

person in five minutes is a good match.

MS. LOVELACE: I promise I won't take

all five minutes.

CHAIRWOMAN KRUEGER: It's okay.

MS. LOVELACE: Hello, everybody.

Thank you for having me. I'm Alyssa

Lovelace. I'm the director for policy and

advocacy at the Home Care Association of

New York State. Al Cardillo wishes he could

be here today; he is our president. He is

teaching class up the street.

HCA represents home care agencies,
hospices and managed long term care plans
throughout the State of New York, along with allied members and other associate members as well, who all support the mission of those home care agencies and managed long-term care plans and hospices.

You have our written testimony. There is a lot in there. And I am going to start by saying that as it relates to the Medicaid Redesign Team, we have asked directly if we could be a participant, but we did not hear anything.

To that end, we have explained the process of MRT and how home care was part of the process -- or actually not part of that process -- and we would like a seat at the table moving forward.

To that end, I just have three quick points that I want to drive home that are positive, that I think that home care, managed long term care, we can actually be of help in this year's budget.

The first is how to improve the healthcare system through the optimization of Medicare. This means having health plans and
providers adopt and follow guidelines that
optimize the use of Medicare services through
providers such as certified home health
agencies and hospices. So they should follow
guidelines by optimizing Medicare, by
ensuring that Medicare is a first payer
before a dual-eligible moves into a Medicaid
product. So essentially, Medicaid should be
the payer of last resort.

We would like to reactivate laws
requiring referrals to hospices, maximize new
potential for extended home healthcare
coverage provisions under the federal Jimmo
settlement. A lot of this is
Medicare-related, obviously. We are talking
next about 222 waivers and using the
flexibilities within those waivers. And that
would come through CMS. It is something that
has been done since the '70s, and so we have
seen them happen, they have been verified.

222 waivers are granted to providers in this
state to allow them more innovative options,
and this is just another path we can take
rather than increase Medicaid expenditures.
The second point is to create efficiencies and strengthen cost-control capabilities in managed long-term care, home care, and the consumer-directed program. So we suggest amending state laws and procedures to allow MLTCs and home care providers better capability to control utilization and costs, create operational and procedural efficiencies including the ability to preempt avoidable visits and elimination of regulatory redundancies.

I think that we can all agree that there are many regulatory redundancies, and we would like to alleviate the Department of Health of some of those. And I think that the Home Care Association, our sister organizations, we can come together and see where there are redundancies within that system.

And finally, prevent organizational practices tied to higher costs. That brings me to the CDPAP program and marketing guidelines. And that is something that we can most certainly talk offline about. It
was talked about earlier today when the commissioner was up, and will be talked about later.

And then finally -- and this really gets to the part about home care and its strengths. So the providers and their workers, they know the communities inside and out. They know the environmental hazards, they are culturally competent, they're aware of the diverse populations. These people are living -- the workers are living and breathing in the homes, they see the communities. What preventative ideas are out there that we can help keep people in their homes and in their communities longer?

HCA last year we released a number of initiatives starting with, of course -- and I'm going to say it out loud -- their sepsis program. There was $195 million in annual fee-for-service Medicare payments for in-home patients that was an attributable savings. To that end, we think that we could move forward budgetarily with this sepsis program. Senator, you were a key factor in that
legislation moving, so thank you.

  We also advanced a $20 million, roughly, asthma management program. And then of course there's telehealth for chronic disease management, such as CHF and diabetes management. And those are two diseases that have a high likelihood of interactions in the healthcare system.

  So at the end of the day, the home care workers, the agencies, they're in the community, and we can definitely be a resource to the Legislature and the Executive as we move forward trying to figure out the budget.

    CHAIRWOMAN KRUEGER: Thank you.

    Senate? Assembly? We're good.

    MS. LOVELACE: Thank you.

    CHAIRWOMAN KRUEGER: Thank you very much for your testimony.

    Moving on to the New York State Association of Health Care Providers,

    followed by New York Public Interest Research Group, followed by a panel of Continuing Care and LeadingAge.
My name is Kathy Febraio. I am the president and CEO of the New York State Association of Health Care Providers. This is Kevin Kerwin, our VP of public policy.

We are a statewide association representing licensed home care services, certified home health agencies, fiscal intermediaries, and related health organizations throughout New York. We are the providers of the long-term care and personal care services that have been referred to throughout the day.

And first and foremost, I want to say that we are very proud of the work that we do and the ability for our patients to be able to stay in their homes with dignity.

Right now our members are reeling from the perfect storm of increases in direct care costs, severely inadequate reimbursement rates, and the lack of adequate and timely contract amendments from the managed
long-term care organizations to cover those
increases in costs.

Now more than ever, it is important
for New York to invest in home care and
protect the viability of this industry so
that we can ensure that individuals with
disabilities, chronic illness, and elderly
populations to continue to have access to
services that allow them to remain in the
comfort and safety of their own homes.

I thank you for your in-depth
questioning today of the Department of Health
regarding the Medicaid budget and the MRT II.
A lot of the details that you identified are
the same concerns that we have. And our
members are worried that -- because during
MRT I the home care industry did not fare
very well, and workgroups were created after
the fact to mitigate issues, but the train
had left the station and it was too late.

So long-term care and personal care
services are the focus of MRT II, or so it
seems. And so the only appropriate and
sensible thing to do is to include our
organization, along with others that
represent these services, as full members of
the MRT.

        We did put in our request to be
members, and we have not yet heard.

        So providers of home care services
have been cut to the bone in recent years and
are operating on razor-thin margins. Many of
our members report that this is compounded by
holding accounts receivable from the MLTCs
for far too long, for hundreds of thousands
of dollars and more, leaving our provider
members facing personal financial crises and
needing to secure personal loans and lines of
credit just to make payroll. More than half
of our members report this situation.

        All the while, the home care industry
has been faced with multiyear licensing
moratoria, the new prospect of the
Certificate of Need process as part of their
licensing, contract limits with managed-care
organizations, increases in minimum wage, and
most recently, a 1 percent cut to Medicaid
effective January 1. All the while, they're
preparing for the implementation of
electronic visit verification coming end of
this year. And none of these efforts improve
the quality of care. In fact, they distract
from it.

So much has been said about long term
care and personal care services today, as if
the home care providers are simply corralling
everly and disabled individuals out on the
streets and providing care to these
individuals without assessment to be eligible
for Medicaid, nor evaluated for the
appropriate care or services.

And I think you uncovered, through
your questioning and interviewing of the DOH,
that that is not the process. We are here to
provide the services that others indicate are
needed.

So has the program grown? Yes, it
has. But it's not due to increased payments
to providers. We've got a growing senior
population, we had shifts of recipients into
the Managed Long Term Care program that have
both provided growth into this program.
Cuts are not the answer. The Medicaid system needs revenue. The state should be investing in and not cutting home care. The alternative will be people are going to need services, and there's going to be no way for them to receive it.

So looking to the consumer directed personal assistance program as an example, about half of our members are fiscal intermediaries. And we urge the Legislature to consider the monumental changes that are going on in that program and look at it as an example of what may happen in Medicaid overall if the $2.5 billion is cut.

CHAIRWOMAN KRUEGER: Thank you.

Any Senate questions? Any Assembly questions?

CHAIRWOMAN WEINSTEIN: Assemblyman Ra.

ASSEMBLYMAN RA: Thank you.

Thank you for being here and for your patience. And, you know, there's no question that your industry has really had a lot of challenges over the years. You've done what has been asked of you in many ways, and still
it seems like there's always something else coming down the pike.

But one of the issues I know we've spoken about many times when you've had your regional meetings is, you know, with the minimum wage and whether the funding that this Legislature approves and sees in the budget then actually gets paid out to you guys in a timely manner. I was wondering if you could just talk a little bit about, you know, where we are with that, how your members are faring with that issue.

MS. FEBRAIO: It continues to be a challenge. We of course on December 31st had another wage increase, and we are still hearing from our members that they're not getting contract changes in a timely manner. And then often when they are getting them, the rate is not covering the minimum wage, the hourly rate.

So there's no room for administrative coverage of that within that cost if you're not even covering the actual minimum wage in direct labor costs. So it continues to be a
problem, along with the long time in paying
those claims. So they're balancing their
books as best they can, but it is becoming
more and more of a challenge.

ASSEMBLYMAN RA: Thank you.

CHAIRWOMAN KRUEGER: Thank you very
much.

MS. FEBRAIO: Thank you.

CHAIRWOMAN KRUEGER: Have a good
evening.

Our next testifier, New York Public
Interest Research Group.

Good evening.

MR. HORNER: Good evening.

CHAIRWOMAN KRUEGER: You've got five
minutes. Don't try to read it.

(Laughter.)

MR. HORNER: We promise not to.

Good evening, my name is Blair Horner.

I'm director of NYPIRG. With me today is
Robert Zentgraf, one of NYPIRG's policy
associates.

You have our written testimony, and we
will use our five minutes to focus on some
key topics. First, healthcare costs.

As you know, the big debate in dealing with the state's budget deficit is the cost of healthcare, since it constitutes a big portion of the shortfall. As part of solving that problem, we urge you to consider how to improve the quality of healthcare in the state.

Research shows that poor-quality care is more expensive than high-quality. Studies published since the 1990s have shown that hundreds of thousands of Americans are injured or killed each year due to substandard hospital care. According to a 2008 analysis, medical mistakes add nearly $20 billion to the nation's healthcare costs. And if such mistakes were spread evenly across the nation, New York would lose roughly $1 billion annually to substandard care.

But substandard care is not spread evenly. According to federal government data, New York hospital care ranks among the nation's worst. That's right. And our
review of the data found that poor-quality rankings apply to all regions of the state.

We've heard a lot about the need to curb costs, which if done incorrectly can merely reduce access to necessary care or weaken health quality efforts. We urge you to demand that improved healthcare quality is part of any Medicaid redesign effort.

Second issue, antibiotics. The rise of antibiotic-resistant super bugs is a worldwide crisis. We're now entering a post-antibiotics era in which the smallest infections, like a UTI, can lead to serious illness or even death.

If nothing changes, experts predict by the middle of this century, more people will die from antibiotic-resistant infections than die of cancer.

Two-thirds of all human-important antibiotics are used on farm animals. The CDC says 20 percent of all antibiotic-resistant infections develop on farms. Twenty percent come from farms. No one disagrees that antibiotics should be used on
sick animals or those exposed to sick
animals, but dousing healthy animals with
antibiotics because they might get sick helps
breed resistant microbes.

So we urge you to add restrictions on
the use of antibiotics in farm settings to
the Governor's proposed efforts in this area.

Robert?

MR. ZENTGRAF: The Governor rightly
proposes to restrict flavored vaping
products. The vaping and tobacco industries
know quite well why they add flavoring to
their deadly products: It makes it easier
for new users to get started, and the vast
majority of these new users are teenagers.

There's a wealth of documentation that
the tobacco industry knows that its
replacement smokers are minors and that
sweet-flavored tobacco products make it
easier for kids to start using. That is why
the FDA banned most flavored cigarettes. But
other products -- cigarillos, cigars and
chewing tobacco -- are still allowed to be
flavored, and menthol cigarettes are still
allowed to be sold.

Tobacco use, including electronic cigarettes, offers no useful contribution to society. These are devices to addict, devices to ruin user's health, and devices that can lead to an early, painful death.

We urge you to expand the Governor's ban on flavored vapes to all tobacco products as well.

MR. HORNER: And as you'll see in our testimony, it details how the state has dramatically reduced its funding of tobacco control programs by more than 50 percent in the last 10 years. And we urge that more money should be included. The money is there. The state receives billions of dollars each year in money from tobacco taxes and the master settlement group. Use it to enhance the state's pro-health efforts.

The Governor's budget also proposes to expand the Physician Profile Program. The critical failure of that program is that no one knows that it exists. There must be notification at all medical settings, on all
websites and social media platforms, that
such profiles exist. And if you want to look
at it, it's NYdoctorprofile.com, provided by
the Health Department, where you can get
background information on doctors.

As patients choose their doctor, they
must have access to public information that
would help them to make a decision that
directly affects their health. The Health
Department also offers a web-based tool to
compare drug prices in pharmacies, and
there's supposed to be a sign at every
counter in every pharmacy telling you where
it is. Have you ever seen one? Not the
retail drug prices available, that's a
different law.

The State Education Department should
enforce the law.

Thank you for this opportunity to
testify.

CHAIRWOMAN KRUEGER: All right. Any
questions?

CHAIRWOMAN WEINSTEIN: Assemblyman
Byrne.
ASSEMBLYMAN BYRNE: Sorry, I can't help myself. I may be wrong, but maybe you can -- a test of my memory here. And I'm hoping you can help maybe explain or reconcile this. Did NYPIRG express concerns about Tobacco 21 last year?

MR. HORNER: That's right. We opposed it.

ASSEMBLYMAN BYRNE: So how do we reconcile that NYPIRG was opposing raising the age to 21, and by all accounts that I've -- at least in my county, enforcement has been going pretty well -- but now they're taking the position to ban flavored vapes?

MR. HORNER: Well, we've been involved in tobacco control issues for over 30 years. We've supported every initiative that is backed by the evidence that would work to curtail smoking and make access harder for minors.

The average age for beginning smokers in New York is 13. Raising it to 21 isn't going to make any difference. And so unless -- if the intent of public policy is
to discriminate against 18-, 19- and
20-year-olds, you achieved it. If the goal
is to reduce access for minors, it won't
work. And that's been the experience in
New York City.

ASSEMBLYMAN BYRNE: Thank you.

MR. HORNER: But you should ban
flavored tobacco products and vapes. Because
that's how you get started, that's how you
get hooked, and that makes it easier for kids
to get to do it. And that's why they exist.
The tobacco documents will tell you that.
It's a plan, they know what they're doing.
They're bad people.

CHAIRWOMAN KRUEGER: Thank you very
much for your extensive testimony that we
only gave a little bit of attention to
tonight.

(Laughter.)

CHAIRWOMAN KRUEGER: We'll talk to you
more.

All right, sorry. You know, Liz gets
a little tired. Continuing Care Leadership
Coalition, along with LeadingAge.
MR. AMRHEIN: Good evening. My name is Scott Amrhein. I'm the president of the Continuing Care Leadership Coalition, and I'm delighted to be here tonight with my colleague Karen Lipson from LeadingAge.

We know we have limited time, so I will submit my formal comments for the record and just hit on a couple of key points. And in fact there's one sort of singular point in my written testimony that I want to focus on.

And we all know that we have a crisis. We know there's a $2.5 billion gap, and we're all here to figure out how to fill it. But even before that gap materialized, we had a crisis brewing and manifesting in New York State in terms of losing high-quality not-for-profit long-term-care providers.

And that was really brought to light by the Attorney General's office, through his Charities Bureau. They issued a report in late 2018 in which they really flagged this as an issue, sounding an alarm over the fact that these high-quality community-based not-for-profit providers are closing or
converting. And they're not being, you know, bought by other not-for-profit providers. They're either out of business or it's another type of sponsorship.

And what they noted is that we're losing, on an annual basis in the last few years, 5 percent of our entire not-for-profit nursing home stock. So to put numbers behind that, in 2011, during the last MRT, we had 252 not-for-profit nursing homes. By 2017, we had only 207, which is a loss of 45 homes over just a six-year period. And that's a real, you know, tragedy for 45 communities where those homes were providing outstanding care.

We're also seeing issues with home care, a lot of challenges there. We're seeing some extraordinary facilities being forced to scale back. And I just want to reflect -- you know, Senator Jackson is no longer here, but he really flagged the issue in Manhattan, where I live. In Washington Heights there's a facility that's been in that community for 150 years, and the people
in that community are duly frightened that
that facility may have issues going on if we
don't change something. And just last night
Community Board 7 had a forum because they're
concerned about the other places in their
district, how are they going to go forward.

So I just want to say, you know, we
have pages of recommendations that we leave
to you to read. But if I can leave one
message, it's that a dual goal of this MRT
process, besides finding a way to close the
gap, really needs to be to establish that
there should be never be an instance in
New York State going forward where an
effectively run, high-quality provider of
long-term-care services will be forced to
sell or close in the future because of
shortfalls in reimbursement or budget savings
actions.

Thank you.

CHAIRWOMAN KRUEGER: Hi.

MS. LIPSON: I'm not sure this is on.

(Off the record.)

MS. LIPSON: My name is Karen Lipson.
I'm an executive vice president with LeadingAge New York. Thank you for the opportunity to testify here today.

LeadingAge New York is an association of not-for-profit and public long-term and post-acute care providers across the continuum of care. Our members include affordable senior housing, home care, nursing homes, assisted living, hospice and provider-sponsored managed long term care plans.

I want to second everything Scott said and support his remarks, but I also want to speak to some broader long-term-care themes.

As several people have recognized here today, demographic change is upon us. Our population is aging, and our baby boomers are in their seventies, and 70 percent of people over the age of 65 are going to need long-term care. So we are in a demographic crisis.

What people have not recognized today is that at the same time that our adult population is rising, our working age adult
population is going down. And so that is why
we're hearing a lot about workforce
shortages. And in the long-term-care sector,
we are experiencing extraordinary workforce
shortages across the state -- not just
upstate, not just in rural areas. Our
members cannot fill open positions at all
levels.

So we need a proactive plan to address
demographic change. There's an impressive
and coherent plan in the budget to address
climate change, but I have not been able to
find anything in the budget to address
demographic change. In fact, instead of
preparing for demographic change, the
long-term-care sector has experienced deep
Medicaid cuts over the past two years. And
if you look at the bar graph in your
testimony, those red bars that are longer
than any other bar show the deep cuts that
the long-term-care system has borne over the
past two years.

Not only have we borne the brunt of
Medicaid cuts, we've been overlooked by
healthcare investments, investments through DSRIP and investments through the Healthcare Facility Transformation Grants. So long-term-care providers have received only a small sliver of that funding.

These cuts and this lack of investment, as Scott pointed out, is destabilizing. Our providers' margins are thin to negative, and providers are closing their doors.

So we ask you to look hard at that $5 billion cut, because it is a $5 billion cut, not a $2.5 billion cut when you gross it up, including the federal funds. Taking $5 billion out of the healthcare delivery system in New York State is not sustainable, and cuts cannot be focused on long-term care year over year and expect long-term care providers to be able to serve our grandparents, our parents and ourselves.

So we ask you to reduce the size of that cut. There must be revenues or savings elsewhere in the budget that can help to fill that gap.
We also have a five-point plan to strengthen the long-term-care delivery system and to build the workforce by driving efficiencies and supporting care in the most appropriate settings.

Point one is workforce, investing in workforce and alleviating some regulatory barriers to developing our workforce. And there's a series of recommendations on that green graphic that you have in your packet.

Supporting the delivery of services in the most appropriate setting, including lower-cost settings like adult care facilities and senior housing, affordable senior housing with services. Investing in infrastructure, technology, specialized services to address the needs of an increasingly medically complex population in nursing homes. Supporting regulatory reforms that eliminate unnecessary fees, including that CON fee, which is going to have a very significant impact on nursing homes that need to upgrade their physical plants. And supporting long-term-care provider-sponsored
managed care programs like PACE programs and Medicaid Advantage Plus programs that integrate the Medicare benefits and funding with the Medicaid benefits and funding to provide a holistic approach to delivering care.

We believe these five steps will put us on a stronger foot to address the needs of our aging population.

Thank you for the opportunity to testify, and I'll take any questions.

CHAIRWOMAN KRUEGER: Thank you.

Questions? Questions? Then thank you both very much for sticking it out with us.

MR. AMRHEIN: Thank you.

MS. LIPSON: Thank you.

ASSEMBLYMAN CAHILL: Thank you.

CHAIRWOMAN KRUEGER: All right, the Associated Medical Schools of New York had to leave and go home.

Does the New York State Area Health Education System have a rep here?

UNIDENTIFIED SPEAKER: They do, but the three individuals who are listed here
could not be here for reasons of illness and
a death in the family.

CHAIRWOMAN KRUEGER: I'm sorry. But
are you ready to testify for them?

UNIDENTIFIED SPEAKER: Well, you have
our testimony. We don't want to keep you
late. But we have been proposed to have our
system more or less eliminated in the
State Budget --

CHAIRWOMAN WEINSTEIN: If you're going
to talk, then you've got to come --

CHAIRWOMAN KRUEGER: Just come say
that in the mic.

Hi. We couldn't really hear you from
up there.

MR. WINGATE: I apologize. And I
didn't intend -- I'm not here with a
statement, and I did not intend to speak this
evening.

CHAIRWOMAN KRUEGER: That's okay.

That's fine.

MR. WINGATE: I'm sorry it's so late.

My name is Rob Wingate. I'm the executive
director of the Catskill Hudson Area Health
Education Center, and we are one of nine healthcare workforce organizations in New York State that are part of the New York State Area Health Education Center system. So we have partnerships with many universities and schools and health provider systems, focused on trying to increase the quantity and improve the quality of the health workforce to meet the needs of underserved populations in the state.

So we are part of a line item in the State Budget. The Governor's proposal recommends the elimination of that line item, which would also have the effect of eliminating our capacity to leverage a federal match on our line item.

So we operate out of the University of Buffalo as a state coordinating unit, and we serve every county and every borough in New York City.

So I'd be happy to take questions if you have them, but you do have the testimony in front of you.

CHAIRWOMAN KRUEGER: Thank you.
Any questions? We appreciate you coming and repping for the rest of your group, and we will review the testimony that was submitted. And thank you for being here tonight.

MR. WINGATE: Thank you. Appreciate your time very much.

CHAIRWOMAN KRUEGER: Thank you.

MR. WINGATE: Good night.

CHAIRWOMAN KRUEGER: All right. Next, Consumer Directed Personal Assistance Association of New York State. Hello, Bryan, I knew you were here somewhere. Bryan O'Malley, executive director.

Good evening.

MR. O'MALLEY: Good evening. Thanks for being here for so long. My name is Bryan O'Malley. I'm executive director of the Consumer Directed Personal Assistance Association.

As you know, last year's budget cut $150 million from CDPA. It was argued this cut would not harm services or wages. However, when these rates were implemented --
thankfully for only six weeks, due to a
successful lawsuit -- our fears came true.
FIs were forced to lower wages to minimum
wage and eliminate the ability of consumers'
workers to work overtime. PAs quit, those
who didn't lost wages, consumers went without
services. I spoke to one man who lost his
home.

    When some plans implemented these
cuts, they used it as an opportunity to reap
windfalls. They cut direct care payments
below cost even at minimum wage. If they
would negotiate, they only negotiated on
administrative rates, saying the direct care
component was take it or leave it.

    A new rate structure based on both a
lack of programmatic understanding and data
led to a preordained outcome where agencies
were forced to cut wages for workers and
consumers then went without needed services
as a result.

    Now, as the Governor convenes a new
MRT, he says he will cut without negatively
impacting Medicaid recipients or services.
To those of us who heard this argument last year, we ask he take a step to show he means it. Withdraw the draft regulations on the new reimbursement for CDPA. The negative impact these rates have on both wages and benefits was apparent. To continue to move forward with them would call into question the desire to avoid cuts that impact current beneficiaries or workers.

Frankly, a large driver of the growth in CDPA has been the efforts to get every person covered. With much of the coverage growth occurring among seniors, it is predictable that usage rates are growing, particularly in long-term care. And this growth -- contrary to what you heard today, this growth is not unreasonable, even if the statistics presented are.

The fact is 13 percent of the managed long term care population amounts to just over 35,000 people, while 4 percent of the growth of population over the age of 75 amounts to over 50,000 people. So, you know, there's lies, damn lies and statistics, and
this falls into the last.

Long term care growth is driven by this aging population. They had been paying unaffordable long-term-care rates out-of-pocket, or family was sacrificing their work and wages to provide that care. Many seniors, particularly those in immigrant communities, weren't aware of their eligibility or were scared to use it until outreach got them to sign up.

If folks get services who do not need them, we should stop that. The state contracts with Maximus to make sure that people need the services they receive. Before anyone can enroll in an MLTC to receive long-term-care services through Medicaid, they must be assessed by Maximus. But the budget blames everyone except Maximus for the growth in long-term-care spending. Why? They have one job.

If we want to cover everyone and want to provide the services they need, the state needs CDPA. If the growth in CDPA were in personal care, Medicaid would be paying
$200 million more per year than it is today.
If 25 percent of that population went to
nursing homes, it would cost us a billion
dollars more. The only way to trim
long-term-care expenses without cutting
access to benefits and services is to invest
in and encourage greater use of
consumer-directed.

In his budget address the Governor
noted that the personal care industry added
36,000 new jobs, or 75 percent of the new
jobs for New York City in the first nine
months of 2019. Despite the long-held
recognition that Medicaid is a primary driver
of local economies, this growth was
identified as a negative. However, the state
spent 6.9 billion on the Regional Economic
Development Councils. When the REDCs spend
money, they create transplants who gentrify
neighborhoods and cost poorer residents their homes.

With CDPA, the state dollars invested
go to workers who live here today. People
are turning around and spending that money on
rent, food, and other local businesses. The money stays here.

This is why CDPANYS stands with the Caring Majority in calling for economic development dollars to be invested not in large companies, but in our Medicaid program and other forms of human capital. We can use these investments to offset the costs to counties and the Medicaid program while improving the quality of jobs we provide and righting the wrongs of the past.

CDPANYS has additional ideas that would more than pay for offsetting or repealing the old funding formula that was put in place last year and the draconian cuts that have already happened. They total over a quarter of a billion dollars, and we'll share that with you offline.

CHAIRWOMAN KRUEGER: Senators, any questions? Assembly?

Thank you very much for being here with us, Bryan.

MR. O'MALLEY: Thank you.

CHAIRWOMAN KRUEGER: And I believe the
last person up for the evening who hasn't
given up on us is Center for Elder Law and
Justice.

And if anyone else in the audience
thinks they're testifying, come down here and
talk to someone.

Hello.

MS. HECKLER: Hi. Thank you for the
opportunity to testify and staying with me.
I was not about to drive back to Buffalo
before I got my little spiel.

(Laughter.)

MS. HECKLER: My name is Lindsay
Heckler. I am a supervising attorney with
the Center for Elder Law and Justice. We are
a nonprofit law firm that provides free civil
legal services to older adults, disabled and
low-income people of Western New York.

We are concerned about the lack of
transparency and public involvement in the
process of determining where to save funds in
the Medicaid budget and the budget at large.

We are specifically concerned about the
Governor's use of the Medicaid Redesign Team
and the backup plan to cut $2.5 billion if MRT does not result in savings.

The intent of the Medicaid program is to provide coverage and access to low-income people and people with disabilities. The program is a lifeline to many and ensures that our older adults and people with disabilities are able to live in the least-restrictive setting of their choosing.

Contrary to the intent of the Governor's budget address, where he blamed the deficit on the Medicaid consumer program and Medicaid managed long term care plans, consumers are not a burden on the taxpayer. Consumers are our parents, siblings, children and friends and are an important and essential part of our society. Their lives should not be subject to politics.

The growth of Medicaid in New York is not a surprise, and funding has been repeatedly pushed off for future handling. This is not the fault of the consumer. Sudden changes and cuts to Medicaid without thought to the consequences will lead to
consumers being harmed, wrongfully
institutionalized, and premature death. This
is not the New York we aspire to be.

During this difficult year we urge the
Legislature to oppose the Medicaid local
district spending reforms. Remember the
state's obligation under Olmstead for people
to live in the least-restrictive setting of
their choice. Ensure Medicaid consumer
representation on any potential changes to
the Medicaid program, and hold Medicaid
managed care plans and providers who accept
Medicaid accountable for controlling costs
and providing quality care and services.

The MRT process is like a
quasi-legislative panel whereby the
Legislature has limited authority and
responsibility for the budgetary changes to
Medicaid. The power to make such change is
with the Executive. With so much power being
under the Executive's authority, it is
essential that the consumer is involved in
decisions made to the Medicaid program. This
is their lives.
We also urge the Legislature to remember New York's obligation under the Olmstead Supreme Court decision, that persons with disabilities have a civil right to receive services in the settings of their choosing. For a time, New York believed in this and developed an Olmstead plan. However, recent actions are taking New York away from this important principle.

One example is the nursing home carve-out that requires consumers who live in a nursing home for more than three months be disenrolled from managed care. This incentivizes the institutionalization of people with disabilities, young and old. There is no incentive for MLTC plans to enroll consumers who have high care needs. Consumers already have a hard time returning to the community from nursing homes. The carve-out is going to make and is in the process of making things worse.

Another example are the attacks on the Consumer Directed Program. We urge you to hold managed care plans and providers that
accept Medicaid accountable for controlling
costs and providing quality care and required
services. The majority of consumers who need
long-term care in the community are enrolled
in MLTC plans. As a result, the consumers
expect that these plans -- and we as
taxpayers expect -- that the plans ensure
access to the services they are supposed to
provide.

However, this is not the case, and we
are seeing consumers, in an effort to receive
some type of care at home, accept arbitrary
reduction in their hours and accept that
staff might not simply show up.

Consumers and others want and deserve
to remain in the community. Substandard
nursing home care in our state occurs too
often, and there is a lack of effective
enforcement of basic care standards by the
Department of Health. A recent example is a
facility in Genesee County where maggots
infested a resident's leg, not once but
twice. Can you imagine seeing your mother
with maggots going down her leg twice within
a week?

In closing, New York prides itself as being the first state in the country to be designated as age-friendly, and that older adults are an economic powerhouse and that health and well-being of all citizens is essential for the state's overall social and economic development. I ask, how long will older adults be an economic powerhouse when they're institutionalized, spend all their resources on care, and leave the workforce early to provide caregiving services to loved ones?

New York cannot turn its back on seniors and the disabled. It is not good public policy to celebrate the expansion of Medicaid and that 95 percent of the state is covered by some form of insurance, then blame those who use the coverage. Consumers and caregivers are not to blame.

The cost of long-term care needs to be addressed, but it should not be done to the detriment of consumers. Thank you.

CHAIRWOMAN KRUEGER: Any questions?
No?

CHAIRWOMAN WEINSTEIN: Mr. Cahill.

ASSEMBLYMAN CAHILL: Ms. Heckler,
thank you for enduring this whole day and
staying as late as you do, and have a safe
trip back to Buffalo.

I just want to thank you for putting a
human face on some of the issues we've been
discussing today, and especially for
reminding us that we have a constitutional
obligation, a New York State constitutional
obligation for the general welfare of every
single human being who lives in this state,
and a court-imposed obligation to take care
of people who are elderly and disabled and
make sure that they are in the
least-restrictive setting possible.

So thank you for your testimony.

MS. HECKLER: Thank you.

CHAIRWOMAN KRUEGER: Thank you very
much.

This draws to conclusion our budget
hearing on Medicaid and healthcare issues.
Thank you all who are watching from home or
from here.

Tomorrow morning's hearing on Human Services starts at 9:30. Same room, same channels. Thank you all.

(Whereupon, the budget hearing concluded at 8:46 p.m.)