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

3 JOINT LEGISLATIVE HEARING

4 In the Matter of the
2020-2021 EXECUTIVE BUDGET ON
5 MENTAL HYGIENE

6 --

7

8 Hearing Room B
Legislative Office Building
9 Albany, New York

10 February 3, 2020
11:09 a.m.
11

12 PRESIDING:

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

16 PRESENT:

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

20 Senator David Carlucci
Chair, Senate Committee on Mental Health and
21 Developmental Disabilities

22 Assemblywoman Aileen Gunther
Chair, Assembly Committee on Mental Health
23

24

1 2020-2021 Executive Budget
Mental Hygiene
2 2-3-20

3 PRESENT: (Continued)

4 Senator Pete Harckham
Chair, Senate Committee on Alcoholism
5 and Drug Abuse

6 Assemblywoman Linda Rosenthal
Chair, Assembly Committee on Alcoholism
7 and Drug Abuse

8 Assemblywoman Ellen Jaffee

9 Senator Luis R. Sepúlveda

10 Assemblyman Michael Cusick

11 Senator George M. Borrello

12 Assemblywoman Kimberly Jean-Pierre

13 Senator Diane J. Savino

14 Assemblyman Angelo Santabarbara

15 Senator John Liu

16 Assemblywoman Melissa Miller

17 Senator Gustavo Rivera

18 Senator Anna Kaplan

19 Assemblywoman Patricia Fahy

20 Senator Fred Akshar

21 Assemblywoman Nathalia Fernandez

22 Assemblyman Charles D. Fall

23 Assemblywoman Mary Beth Walsh

24 Senator Sue Serino

1 2020-2021 Executive Budget
Mental Hygiene
2 2-3-20

3 PRESENT: (Continued)

4 Assemblywoman Marianne Buttenschon

5 Senator Elizabeth O'C. Little

6 Assemblyman David I. Weprin

7 Assemblywoman Carmen N. De La Rosa

8 Senator Robert Jackson

9 Assemblyman William Colton

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11

12 LIST OF SPEAKERS

13

	STATEMENT	QUESTIONS
14 Ann Marie T. Sullivan Commissioner 15 NYS Office of Mental Health	12	17
16 Theodore Kastner Commissioner 17 NYS Office for People With Developmental Disabilities	102	107
18 Arlene González-Sánchez 19 Commissioner NYS Office of Addiction 20 Services and Supports	161	167
21 Denise M. Miranda Executive Director 22 NYS Justice Center for the Protection of People with 23 Special Needs	214	220

24

1 2020-2021 Executive Budget
Mental Hygiene
2 2-3-20

3 LIST OF SPEAKERS, Continued

	STATEMENT	QUESTIONS
Harvey Rosenthal Executive Director NY Association of Psychiatric Rehabilitation Services	240	
Glenn Liebman CEO Mental Health Association in New York State	245	252
Wendy Burch Executive Director National Alliance on Mental Illness of New York State (NAMI-NYS)	256	
Kelly A. Hansen Executive Director NYS Conference of Local Mental Hygiene Directors	261	267
Kevin Allen Chair Donna Tilghman Secretary Local 372 NYC Board of Education Employees, DC 37 -on behalf of- Substance Abuse Prevention and Intervention Specialists (SAPIS)	276	280
Angelia Smith-Wilson Executive Director Allison Weingarten Director of Policy Friends of Recovery New York	284	288

24

3 LIST OF SPEAKERS, Continued

		STATEMENT	QUESTIONS
4			
5	Ken Robinson Executive Director		
6	Research for a Safer New York	291	296
7			
8	Christine Khaikin Health Policy Attorney Legal Action Center	302	306
9			
10	Erik Geizer Deputy Executive Director The Arc New York	309	
11			
12	Lauri Cole Executive Director NYS Council for Community		
13	Behavioral Healthcare -and-		
14	Andrea Smyth Executive Director		
15	NYS Coalition for Children's Behavioral Health	315	324
16			
17	Yvette Watts Executive Director NY Association of Emerging		
18	& Multicultural Providers -and-		
19	Susan Constantino President and CEO		
20	Cerebral Palsy Associations of New York State		
21	-for- New York Disability Advocates		
22	-and- Michael Seereiter		
23	President/CEO New York Alliance for		
24	Inclusion & Innovation	331	346

1 2020-2021 Executive Budget
Mental Hygiene
2 2-3-20

3 LIST OF SPEAKERS, Continued

	STATEMENT	QUESTIONS
John J. Coppola Executive Director NY Association of Addictive Services and Professionals -and- Amy Dorin President and CEO The Coalition for Behavioral Health	354	366
William T. Gettman, Jr. CEO Northern Rivers Family of Services	372	
Antonia Lasicki Executive Director Association for Community Living -for- Bring It Home Coalition	376	382
Paige Pierce CEO Families Together in NYS	384	
Jim Karpe NYC FAIR -on behalf of- StateWide Advocacy Network (SWAN)	391	395

20
21
22
23
24

1 CHAIRWOMAN KRUEGER: Good morning. My
2 name is Liz Krueger. I am the chair of the
3 New York State Senate Finance Committee and
4 cochair of today's budget hearing.
5 Today is the fifth of 13 hearings
6 conducted by the joint fiscal committees of
7 the Legislature regarding the Governor's
8 proposed budget for state fiscal year
9 2020-2021. These hearings are conducted
10 pursuant to the New York State Constitution
11 and Legislative Law.
12 Today the Senate Finance Committee and
13 the Assembly Ways and Means Committee will
14 hear testimony concerning the Governor's
15 proposed budget for the Office of Mental
16 Health, Office for People With Developmental
17 Disabilities, Office of Alcoholism and
18 Substance Abuse Services, and the Justice
19 Center for the Protection of People With
20 Special Needs.
21 Following each testimony there will be
22 some time for questions from the chairs of
23 the fiscal committees and other legislators.
24 I will now introduce members of the

1 Senate, and afterwards Helene Weinstein will
2 introduce members of the Assembly.
3 So for the Senate Democrats, we have
4 Senator David Carlucci, Senator Pete
5 Harckham, Senator John Liu, Senator Luis
6 Sepúlveda, Senator Diane Savino, Senator Anna
7 Kaplan and Senator Gustavo Rivera.
8 And for my Senate Republicans, James
9 Seward is the ranker on Finance.
10 SENATOR SEWARD: Thank you, Madam
11 Chair. I'm pleased to introduce, from my
12 conference, Senator Fred Akshar and Senator
13 George Borrello.
14 CHAIRWOMAN KRUEGER: Thank you.
15 Assembly.
16 CHAIRWOMAN WEINSTEIN: We have with us
17 Aileen Gunther, chair of our Mental Hygiene
18 Committee, Assemblyman Cusick, and
19 Assemblywoman Jaffee.
20 And now our ranker, Assemblyman Ra,
21 will introduce members of his conference.
22 ASSEMBLYMAN RA: Thank you.
23 We're joined by Assemblywoman Missy
24 Miller, our ranking member on the Mental

1 Hygiene Committee, as well as Assemblywoman
2 Mary Beth Walsh.
3 CHAIRWOMAN KRUEGER: Great. All
4 right. So after the final question-and-
5 answer period of the relevant government
6 representatives, there will be an opportunity
7 for members of the public to briefly express
8 their views on the proposed budget under
9 discussion.
10 Just some of the rules of the road
11 here. We discourage protests that interrupt
12 the flow of the hearing. If you like
13 something you're hearing and you want to do
14 this (gesturing), that's fine. If you don't
15 like it, you're of course welcome to testify
16 or let us know in lots of ways, preferably
17 not interrupting the flow of the hearing.
18 Please pay especially close attention
19 to the time clocks if you are one of the
20 people testifying. Government
21 representatives have 10 minutes to present;
22 members of the public will have five minutes
23 to present. For both, please don't imagine
24 you're going to read your full testimony. If

1 you're showing up with more than two pages of
2 testimony, you won't get through it. So you
3 want to think about bullet-pointing the
4 critical issues that you want to make sure we
5 know about.
6 We are all getting copies of
7 everyone's testimony. The testimony is going
8 up online for anyone to pull up and read and
9 review. This hearing is being live-streamed.
10 There's lots of opportunities for you to
11 participate even if you're not here with us
12 today.
13 Chairpersons of the relevant
14 committees have a 10-minute allotment for
15 questions and answers of governmental
16 witnesses; all other legislators who are
17 members of the relevant committees receive
18 just five minutes.
19 And except for the relevant chairs,
20 there will be no second round of questioning.
21 Relevant chairs can have a five-minute second
22 round if they need it.
23 Any legislator who feels the need to
24 ask additional follow-up questions but

1 doesn't have a second round, please present
2 them to either Helene Weinstein, my cochair,
3 or me, and at our discretion we may ask those
4 questions of the witnesses.
5 For nongovernmental witnesses, all
6 legislators only have three minutes to ask
7 the witnesses.
8 I think I've covered sort of the rules
9 of the road. Oh, one more thing. Please
10 when you're testifying speak carefully into
11 the microphone as close as you can to your
12 mouth. We do not have an ideal system. And
13 also for those of us who are up here on the
14 daises, if you're not speaking into your mic,
15 please turn it off. Because you don't know
16 that the mic is hot and everyone listening in
17 on their computers somewhere outside of this
18 room is hearing everything every one of us
19 says.
20 So if you don't really want to share
21 that information, make sure your mic is off,
22 because you won't realize what's happening,
23 but people text in and call in saying, "That
24 was so interesting, Liz," "Why were you

1 saying that, Helene?" So let's be very
2 careful.
3 On that note, I would like to invite
4 up Commissioner Sullivan, from the Office of
5 Mental Health.
6 COMMISSIONER SULLIVAN: Good morning.
7 I'm Dr. Ann Sullivan, commissioner of the
8 New York State Office of Mental Health.
9 Chairs Krueger, Weinstein, Carlucci,
10 Gunther and members of the respective
11 committees, I want to thank you for the
12 invitation to address OMH's 2020-2021
13 proposed budget.
14 I would like to thank the Legislature
15 for your continued support of reinvestment
16 funding, which emphasizes providing care in
17 community-based settings. Since 2014, with a
18 commitment of more than $100 million in
19 annualized investments to date, OMH has been
20 able to provide services to more than
21 70,000 new individuals, bringing the total to
22 over 800,000 people served in the public
23 mental health system.
24 Examples of the new community services

1 that have been funded are supported housing
2 units, child and adolescent crisis/respite
3 beds, clinic program expansion, additional
4 OnTrackNY teams, crisis intervention teams,
5 assertive community treatment or ACT teams,
6 and long-stay transition support teams.
7 Because these community services are
8 available, New Yorkers can get the support
9 they need to avoid hospitalization, access
10 inpatient services only when needed, and live
11 successfully in their communities.
12 Building on these investments, the
13 2020-'21 Executive Budget recommends
14 significant investments for the OMH
15 not-for-profit workforce. These investments
16 include resources to leverage over $40
17 million in new annual funding to provide
18 targeted compensation increases to direct
19 care, support and clinical staff, and to
20 support provider costs for minimum wage
21 increases.
22 The Executive Budget increases support
23 for OMH housing initiatives by an additional
24 $20 million for existing residential

1 programs. Since 2015, OMH support for these
2 programs will have increased by $70 million.
3 Additionally, the budget includes $60 million
4 in capital to maintain and preserve
5 community-based residences. The budget
6 provides an additional $12.5 million for
7 certain individuals living in transitional
8 adult homes in New York City who wish to
9 transition to more integrated settings in the
10 community.
11 The comprehensive parity reform
12 enacted last year will enhance state
13 oversight of insurers and require them to
14 apply the same treatment and financial rules
15 to behavioral health services that are used
16 for medical and surgical benefits.
17 Importantly, this new law authorizes OMH to
18 review and approve medical necessity criteria
19 used by plans.
20 Additionally, the creation of the
21 Behavioral Health Ombudsman program,
22 otherwise called CHAMP, Community Health
23 Access to Addiction and Mental Health Care,
24 and the enactment of the Mental Health

1 Substance Use Disorder Parity Reporting Act
2 have assisted individuals and their families
3 in accessing behavioral health services.
4 CHAMP has handled 1,600 cases while providing
5 education to an additional 5,000 individuals,
6 family members, caregivers, or providers.
7 In October 2015, New York State was
8 one of 23 states awarded a one-year planning
9 grant and an implementation grant two years
10 later from the federal government to create
11 Certified Community Behavioral Health
12 Clinics. CCBHCs improve health outcomes
13 through increasing access to care; reducing
14 avoidable hospital use; and providing
15 behavioral health care entities in
16 underserved areas with more financial
17 stability; and integrating mental health,
18 substance use, and physical health services.
19 OMH's experience has been increased access to
20 enhanced behavioral health services and
21 decreased need for acute care for both mental
22 and physical health.
23 School-based mental health clinics are
24 another area where New York State continues

1 to increase access to treatment by providing
2 services on-site. Currently there are 806
3 school-based mental health clinics in New
4 York State. Three years ago, there were less
5 than 300 such clinics.
6 Suicide prevention continues to be a
7 priority issue. OMH has partnered with state
8 agencies and communities to implement
9 recommendations from the Governor's Suicide
10 Prevention Task Force. The Task Force also
11 identified gaps in suicide prevention efforts
12 and made recommendations to identify at-risk
13 populations where increased engagement
14 efforts are needed, including Latina youth,
15 the LGBTQ community, black youth, veterans,
16 and individuals living in rural communities.
17 The FY 2021 Executive Budget includes
18 a plan to transform the Kingsboro PC campus
19 into a recovery hub facility, focused on
20 shortening lengths of stay and providing
21 centralized community support services,
22 including a step-down transition to a
23 community residence program. This transition
24 is consistent with OMH's patient-centered

1 approach to care with an emphasis on
2 recovery.
3 Finally, OMH's goal is to increase
4 access to prevention and community services,
5 intervening prior to the need for more
6 intensive and costlier care. For those who
7 continue to need inpatient hospitalization,
8 New York State has the highest number of
9 psychiatric inpatient beds per capita of any
10 large state in the nation, and we will
11 continue to preserve access to inpatient care
12 as we transform the system.
13 Again, thank you for this opportunity
14 to report on our efforts to support and
15 continue the work that we have jointly
16 embarked upon to transform New York's mental
17 health system.
18 Thank you.
19 CHAIRWOMAN KRUEGER: Thank you.
20 First up, Senator David Carlucci.
21 SENATOR CARLUCCI: Thank you, Madam
22 Chair.
23 And thank you, Commissioner Sullivan.
24 Thank you for your commitment to our

1 community and protecting some of our most
2 vulnerable populations.
3 As you know, we've spoken at length
4 about many of the issues that you're working
5 on. I wanted to start off with our
6 commitment to our workforce. And, you know,
7 we've shared conversations about how
8 important it is that we invest in our
9 workforce, that we encourage the longevity of
10 our staff, and that we make sure that we
11 don't have this transition that we are
12 consistently having to retrain and also we're
13 providing a lack of service to the
14 individuals we serve if we have that
15 transition consistently.
16 You know, last year we had a victory
17 in including a 2 percent wage increase across
18 the board for our human service workers. We
19 find now we're hearing from service
20 providers, they tell us that that wage
21 increase has not yet been released. It was
22 supposed to go out January 1st.
23 Do you know anything about that? Can
24 you tell us about that?

1 COMMISSIONER SULLIVAN: Well, as far
2 as I know, it's set to be released as soon as
3 possible. So I don't know the exact date, I
4 can't say that to you. But I can get you
5 that information afterwards.
6 But I -- there is another 2 percent
7 increase in this year's budget as well, which
8 will be 2 percent and then 4 percent for
9 direct care workers in April, and another 2
10 percent for clinical care workers.
11 So these increases are very real. I
12 know that sometimes there might be a delay,
13 but they are very real and they will happen.
14 SENATOR CARLUCCI: Okay, thank you.
15 And just to get into some of the
16 nuances of the budget, we've worked together
17 on suicide prevention; my colleagues in the
18 Senate, we passed a bunch of different pieces
19 of legislation to try to tackle the increases
20 that we've seen in suicide rates across the
21 board.
22 And one, I want to thank you for the
23 recent report that was put out from OMH on
24 suicide prevention. We passed the

1 legislation on the black youth suicide. And
2 I know you've been working with Dr. Lindsey
3 on how we integrate and make sure that we're
4 working specifically in that area.
5 Would you be able to give us any
6 information on what's going on with that,
7 what you plan to do and what we can see in
8 this year in terms of outreach to the black
9 youth community and across the board on
10 suicide prevention?
11 COMMISSIONER SULLIVAN: For sure, yes.
12 And first of all, I want to thank the
13 legislative members for their interest and
14 for their commitment to suicide prevention.
15 I think everyone who speaks to this helps to
16 decrease the stigma and helps to bring to
17 everyone's attention the importance.
18 On the black youth suicide, we have
19 had conversations with Dr. Lindsey, who is
20 the national expert in this area. It's a
21 very tragic fact that young black youth, ages
22 -- as early as 10 years old, there's been a
23 significant increase in suicide.
24 They published, through his work, a

1 report from the national caucus, the
2 Congressional Black Caucus, which outlines a
3 whole series of steps to work on how to
4 address this issue. Those steps include
5 things like research -- it's one of the
6 things he's looking for. Other things,
7 though, include working with communities,
8 working with faith-based organizations, and
9 doing a great deal of intervention in
10 schools.
11 And what we're going to be doing with
12 Dr. Lindsey is targeting the particular
13 areas. We have -- through our databases, we
14 can pick out particular hotspots where there
15 have been a number of suicide attempts or
16 particular problems within certain
17 communities, and we'll be doing that in the
18 black youth community. We'll be working with
19 the schools in those areas, the faith-based
20 organizations, parents, outreach campaigns to
21 increase the community's awareness and
22 understanding of the problem.
23 And we're doing a similar effort with
24 other groups as well. It's going to be a

1 similar approach with Latina youth. We have
2 Dr. Silva from Rochester who's assisting us
3 with that. And we're doing it with rural
4 issues. There's a high incidence of suicide
5 in rural communities. And we're going to be
6 doing it for veterans, law enforcement, and
7 for LGBTQ communities.
8 So in addition to the overall suicide
9 approach, which is general public awareness,
10 which includes a lot of training in
11 schools -- over 25,000 trainings last year,
12 individuals who were trained -- we are also
13 targeting specific high-risk communities, and
14 we will be doing that in conjunction with the
15 various community agencies that work with
16 those groups, with the counties, with
17 everyone else, to ensure that we get the word
18 out. It's a multifactorial problem, suicide.
19 And the other area -- not to take too
20 much time, the other area we're working very
21 intensely with is the provider, both on the
22 health side and on the mental health side.
23 So for example, there's an initiative now in
24 90 emergency rooms across the state to do

1 better follow-up after suicide in the --
2 SENATOR CARLUCCI: I'm sorry, 90 what?
3 COMMISSIONER SULLIVAN: Emergency
4 rooms, medical emergency rooms across the
5 state, to do improved follow-up and treatment
6 of individuals who come in post-suicide
7 attempt.
8 SENATOR CARLUCCI: Could you touch on
9 -- we were really excited to see, in the
10 Executive Budget, a million dollars dedicated
11 to suicide prevention for veterans and first
12 responders, law enforcement. We've seen a
13 spike, unfortunately, in law enforcement
14 suicide rates. Could you tell us about how
15 that money will be utilized?
16 COMMISSIONER SULLIVAN: Yeah, we're in
17 the process of planning that. You know, I
18 think that -- first of all, it's very
19 exciting to have the dollars for a campaign
20 for suicide prevention anti-stigma. But
21 we're going to be working very closely with
22 the law enforcement agencies and the first
23 responders. They know best how to work with
24 the individuals in their forces. So we're

1 working with the State Police, with the New
2 York City PD, and we're working with all of
3 the veterans organization, the state veterans
4 organizations, the Office of Victim Services,
5 interagency.
6 And I think within -- probably within
7 six to eight weeks we'll have a plan that
8 we'll be able to come out with. But we
9 really need the input of those -- they're
10 groups, groups that have worked with those
11 individuals. When you work with law
12 enforcement, it's very important that
13 individuals who work with them understand the
14 issues of law enforcement. And so we're also
15 going to be doing some training of staff so
16 that individuals will be available for
17 services. That's one of the issues, to have
18 enough individuals who understand the issues
19 of law enforcement and first responders in
20 treating individuals who may need treatment
21 in order to prevent suicide.
22 SENATOR CARLUCCI: Okay, thank you.
23 And we have been working extensively on
24 eating disorder issues and knowing that if we

1 put the right policies in place, we can help
2 a lot of people and diagnose them early to
3 get the treatment that they need.
4 And I know there's been a move for a
5 transfer of the Comprehensive Center for
6 Eating Disorders from the Department of
7 Health to the Office of Mental Health. Could
8 you briefly tell us about that and tell us --
9 you know, we're really looking for the
10 reassurance that that program will continue
11 and not be at jeopardy now being under the
12 auspice of the Office of Mental Health.
13 Can you tell us, has the money come
14 with it from the Department of Health? What
15 safeguards will be in place to make sure that
16 that not only continues but expands?
17 COMMISSIONER SULLIVAN: I think, first
18 of all, it's a great need and there's a
19 commitment on the part of the Office of
20 Mental Health to ensure that it continues.
21 In terms of the dollars, the $118,000
22 that was in the Executive Budget is coming
23 with it. The other million dollars which
24 traditionally has supported these eating

1 disorder specialty centers, and there are
2 three across the state, has been a
3 legislative add in each year. So that -- to
4 the Department of Health, which is a
5 different agency than the office of OMH.
6 So there are discussions going on
7 right now about that additional add, which
8 has been there over time to support these
9 centers. They're very important. They
10 really are the places -- the three places --
11 I think it's Rochester; it's the city, at
12 Columbia; and it's in the Albany area --
13 where people go for the expert help that they
14 can need for the major eating disorders.
15 They also do a lot of outreach for the
16 general population in terms of obesity and
17 other issues. So there is a great commitment
18 to continue these. There is the question of
19 the money, which will be discussed, I think,
20 over the budget negotiations.
21 SENATOR CARLUCCI: Yeah, it's
22 something I'm very concerned about, because
23 there is that million-dollar reduction and
24 now it's coming from the Department of Health

1 to OMH. So that's something we're going to
2 have to work closely on. I'm hopeful that
3 possibly the Governor, in his 30-day
4 amendments, will include that million dollars
5 in the OMH budget to make sure that this
6 doesn't fall off the table.
7 There's so much we need to talk about,
8 but I know our time is limited. We talk
9 about, in your opening statement, the
10 transition from adult homes to supportive
11 housing. There's money in there for New York
12 City. How about the rest of the state? As
13 well as the Governor said in his State of the
14 State the commitment towards supportive
15 housing. Where can we point to in the budget
16 that shows us where those dollars are to
17 build the supportive housing that we need?
18 COMMISSIONER SULLIVAN: Yeah, the --
19 throughout the -- there are points in the
20 budget, I think it's a total of $12.5 million
21 which is going for the adult home in the
22 city.
23 There are an additional 1200 units in
24 the budget, not including those 500, that are

1 going to be opening up as part of the
2 pipeline for the rest of the state. Those
3 will be distributed across the state. And
4 basically that includes a combination of
5 funding from the ESHI, the Empire State -- it
6 includes some funding from the old
7 New York/New York III housing. So throughout
8 the budget there are line items which talk to
9 the amount of dollars that are there.
10 But it will -- and maybe I misspoke
11 for a minute. I think the 500 are in there.
12 So I think it's a commitment of 1200
13 including the 500, I don't -- yes, including
14 the 500 adult home slots. But the other 700
15 will be distributed across the state in
16 various areas. Which is what we have
17 traditionally done with all the housing that
18 has come up. Basically we look at areas
19 where it's needed, we get developers who
20 hopefully can put up the housing.
21 Also last year we had an additional
22 250 slots for homeless, a number of those
23 slots for apartments. A number of those were
24 upstate -- in fact, a good number of them

1 were also upstate.
2 So we try to distribute as best we can
3 the housing across the state, and it's all
4 kind of lined-itemed out in the budget under
5 the housing sections, so ...
6 SENATOR CARLUCCI: As far as OMH, how
7 many housing units do you believe we will
8 have?
9 COMMISSIONER SULLIVAN: There will be
10 1200 new ones this year. There were
11 approximately 1200 last year for OMH. That
12 includes the adult homes and additional
13 housing through ESSHI and New York/New York
14 III.
15 So the total number of housing units
16 in the state now is 47,000, which is really
17 great. It probably -- not probably, is the
18 largest commitment to supportive housing in
19 the country for the seriously mentally ill.
20 SENATOR CARLUCCI: I see I'm out of
21 time. Thank you, Commissioner.
22 COMMISSIONER SULLIVAN: Thank you.
23 CHAIRWOMAN KRUEGER: Thank you.
24 Assembly.

1 CHAIRWOMAN WEINSTEIN: Thank you.
2 We've been joined by Assemblywoman
3 Fahy, Assemblyman Santabarbara, and
4 Assemblywoman Fernandez.
5 And we now go to our Mental Health
6 chair, Assemblywoman Gunther.
7 CHAIRWOMAN KRUEGER: And as she's
8 about to speak, I also forgot to introduce
9 Senator Sue Serino and Senator Akshar, who
10 both joined us.
11 ASSEMBLYWOMAN GUNTHER: Thank you for
12 joining us today, Commissioner.
13 I wanted to start off regarding the
14 funding crisis for our mental health
15 providers. Last year we were able to
16 increase for direct support professionals;
17 however, the increase was still below the
18 rate of inflation, and mental health
19 clinicians only received 2 percent beginning
20 April 1st.
21 As you know, this year the mental
22 health and developmental disability community
23 is united around a 3 percent increase over
24 five years. We have been seeing raises in

1 other sectors of healthcare. We are losing
2 our workers in this system left and right, as
3 you well know. We know that the turnover in
4 the DSP community is tremendous.
5 And, you know, as a nurse myself, Ann,
6 we realize that these DSPs, they create
7 relationships with their patients and their
8 loss is a loss to the patient.
9 My question to you, then, is what can
10 we do to impress upon the second floor that
11 these raises are desperately needed.
12 COMMISSIONER SULLIVAN: The budget
13 does include a 2 percent increase for direct
14 care workers as of January, and another 2
15 percent in April, and also in April for
16 clinical care workers. And that's similar to
17 what it was last year, and there was an
18 agreement that that would be in the budget
19 this year.
20 I think that's about $25 million to
21 the Office of Mental Health, including the
22 minimum wage increases. And basically, it
23 does help significantly, I think, to support
24 in some ways. There's always a question of

1 whether more is needed, but I do think this
2 is a significant contribution to the
3 workforce on the mental health side. And
4 when you add in the -- it's $40 million when
5 you add in the contributions from the federal
6 share and the annualization of the dollars.
7 So that's very real, it's in the
8 budget, and it will happen this year. It's
9 been about -- over five years, about a
10 14 percent increase for direct care workers.
11 ASSEMBLYWOMAN GUNTHER: Well, I think
12 it's much needed. But I would say that most
13 of the workforce are women. And honestly, to
14 have an apartment, it's really not a living
15 wage. I live in an area where the delivery
16 of care to people with disabilities, most of
17 our employees are connected with those kinds
18 of jobs, mostly women. You know, we have an
19 issue with daycare. And also to get an
20 apartment, feed your children, it's just not
21 a living wage. It's just not.
22 And we've lagged behind for years and
23 years before. We're doing some catch-up, but
24 we really have to do more, Ann. I know that

1 you're on the same page, but I'm hoping that
2 the second floor will take a look at it
3 and -- rather than -- this is economic
4 development, making sure that these doors
5 stay open. So rather than invest in new
6 economic development, keep what we have. So
7 my piece.
8 A recent study by the Council of
9 School Superintendents showed that more than
10 two-thirds of school superintendents report
11 that improving mental health services is
12 their top priority.
13 I know OMH has done a good job of
14 expanding satellite offices in schools, but
15 I'm wondering why the Executive would decline
16 to continue the enhanced rates for children
17 -- children's behavioral health providers.
18 COMMISSIONER SULLIVAN: The enhanced
19 rate -- the rates were set, and there were
20 start-up rates initially -- for six months,
21 25 percent, then going down to 12.5 percent.
22 And it was always known that basically those
23 start-up rates would end. And the
24 start-up-rate date for the start-up rates to

1 end was January 1st. So yes, those start-up
2 rates have been discontinued, the increase.
3 However, the long-term commitment to
4 the expansion, which is considerable --
5 because it's important to remember that these
6 services were designed to expand services to
7 youth. And basically before the legislation
8 and before this change in services, youth had
9 to be -- they had to kind of almost fail
10 first to get these services.
11 So basically the redesign has enabled
12 youth and families to get the services sooner
13 and for more to get those services. So the
14 end result after these services are up and
15 running, over time, is an expectation that
16 there will be a considerable increase in
17 services for kids and a considerable amount
18 of money spent on those services.
19 So that has not changed. That
20 commitment is still there, even though the
21 start-up dollars, yes, have been discontinued
22 as of January 1st.
23 ASSEMBLYWOMAN GUNTHER: Thank you.
24 According to the United States

1 Interagency Council on Homelessness, New York
2 State has more than 90,000 people
3 experiencing homelessness. That's roughly 3
4 times that of Florida, a state that has about
5 2 million more people than us.
6 Granted, not every person who is
7 homeless has mental illness, but we know many
8 do. Most aren't logging onto the OMH website
9 or calling the field offices to look for
10 service. How can we better reach these
11 folks?
12 COMMISSIONER SULLIVAN: Well, we've
13 been doing a lot of outreach in terms of --
14 just for New York City, as an example,
15 there's --
16 ASSEMBLYWOMAN GUNTHER: So explain --
17 so there's two things I want to know.
18 Explain what we mean by what outreach, and
19 how we're doing it, number one. And New York
20 City is one area --
21 COMMISSIONER SULLIVAN: Absolutely.
22 ASSEMBLYWOMAN GUNTHER: -- but we're
23 looking at low-income areas in the middle of
24 the state and other areas. So we're not just

1 going to be tunnel vision on New York City.
2 COMMISSIONER SULLIVAN: No. No.
3 Absolutely. I'm sorry to say that. So I'm
4 not -- I'm not --
5 ASSEMBLYWOMAN GUNTHER: I know, but I
6 just have to say that, because a lot of times
7 we talk about New York City.
8 COMMISSIONER SULLIVAN: No, I
9 appreciate that.
10 No, the issue here is that there's
11 various -- well, it's a -- absolutely,
12 homelessness is a complicated issue. For the
13 seriously mentally ill, the group that often
14 people see and have a lot of questions about,
15 are the individuals who are on the streets.
16 And they are in the streets in many ways, and
17 homeless, not in great situations, throughout
18 the state, not just in New York City.
19 But there's a number of things that we
20 have done. One is the homeless outreach
21 teams, through county aid to many of the
22 counties as well as the city. That county
23 aid goes to homeless outreach teams. What's
24 a homeless outreach team? These are

1 individuals who go out to work with the
2 seriously mentally ill on the streets to help
3 them try to accept services. And for a
4 variety of reasons -- to some extent it's
5 sometimes the way they see the world, it's
6 sometimes the way they want to live. It's
7 very difficult to engage some of these
8 individuals.
9 So we do spend a fair amount -- it's
10 almost $10 million, $12 million across the
11 state, to work on these outreach teams which
12 we fund through county aid. And we monitor
13 that.
14 The second area is working in the
15 various shelter systems. To the extent that
16 they can be safe havens is one way -- one
17 name that we have for some of these. And we
18 do a lot of that work as well.
19 We also have ACT teams that we have
20 funded to work with the homeless, and they
21 help the homeless transition from these safe
22 haven shelters into apartments and give them
23 the kind of wraparound supports that they
24 need.

1 So that's when you've found someone
2 who's already homeless and on the streets.
3 But the bigger piece of this is not to get
4 people homeless and on the streets and to
5 help provide the services that prevent that
6 from happening. And that we've been working
7 very diligently with a whole series of crisis
8 stabilization centers, crisis services,
9 increasing intensive outpatient services,
10 working with increased diligence on discharge
11 planning when people leave the hospitals, so
12 they don't get to the point where they've
13 decided in some level that their home is on
14 the streets.
15 So there's a number of things that
16 have to happen: The preservices, to make
17 sure that people don't become homeless; and
18 then if they do, especially if they have
19 trouble accepting services -- and the biggest
20 part of helping people accept services is
21 trust and engagement and connection. And
22 that takes time. And that's why we fund
23 these outreach teams that get to know the
24 individuals who live on the streets and

1 really work intensively with them.
2 ASSEMBLYWOMAN GUNTHER: How is the $12
3 million distributed?
4 COMMISSIONER SULLIVAN: I think it's
5 about 9 million to the city, and then there's
6 another series of dollars which go to the
7 counties. I could get you the exact dollars
8 for that.
9 ASSEMBLYWOMAN GUNTHER: So there's
10 9 million to New York City.
11 COMMISSIONER SULLIVAN: Mm-hmm.
12 ASSEMBLYWOMAN GUNTHER: But that's
13 half the population of New York State. And
14 the other half of the population gets
15 3 million? If it's 12 million, that's my
16 calculation.
17 COMMISSIONER SULLIVAN: Well,
18 approximately -- I can get you approximately
19 what it is through county aid. It depends on
20 the counties and how it's distributed.
21 But again, there's outreach teams and
22 then there are housing. And the other big
23 piece that we have distributed across the
24 state in housing -- and upstate gets

1 approximately half of the increases in the
2 housing that we do in terms of some of the
3 stipends, et cetera. That prevents the
4 homelessness as well.
5 So the housing -- and it also depends
6 on the number of street people in each
7 particular county. So it can vary from
8 county to county, depending upon the number
9 of people on the streets.
10 But the housing is distributed across
11 the state, and that's pretty much distributed
12 by population base in the various counties.
13 ASSEMBLYWOMAN GUNTHER: We are
14 spending a tremendous amount of money in
15 upstate New York housing our homeless in
16 hotel rooms for big dollars, so much more
17 than if they had stabilized housing. And
18 also their health isn't good, mental health
19 isn't good.
20 And so to me, if we could look at that
21 in terms of money saving and healthier
22 people -- because right now I represent
23 Sullivan and Orange County. Most of my
24 homeless population are in less than

1 adequate, horrible hotels. Because when
2 someone is considered homeless, they have
3 this idea in their head that they're like bad
4 people. So certain hotels won't take those
5 folks or for that rate that the county gives
6 them.
7 So I think we could do a lot better
8 and a lot more if we really provided more
9 stabilized housing, not only in New York
10 City, but in upstate New York you have
11 Buffalo, you have Syracuse, and we have it
12 all. You know, we all share part of that
13 population.
14 CHAIRWOMAN WEINSTEIN: Thank you.
15 We've been joined by Assemblyman Fall.
16 Senate now?
17 CHAIRWOMAN KRUEGER: Thank you.
18 Senator Pete Harckham.
19 SENATOR HARCKHAM: Thank you,
20 Madam Chair.
21 Commissioner, good to see you, as
22 always. Thank you.
23 I just have one question for you. In
24 my work as chair of Alcoholism and Substance

1 Abuse -- and with colleagues up here, we just
2 toured the state focused on the opioid
3 crisis. And so much of -- and the science
4 now ties it with co-occurring disorders, the
5 nexus of mental health with substance use
6 disorder, the notion of self-medication.
7 And I know you and OASAS have been
8 working closely on the blended license, which
9 is a step -- a big step in the right
10 direction. But one of the things that we've
11 heard from people, both providers and from
12 patients all across the state, is there are
13 still obstacles with billing and paying.
14 That they can now go to one treatment center,
15 but they are still treated differently in
16 terms of the billing stream. So there's
17 seeing a peer for substance use disorder is
18 one bill, seeing a mental health counselor is
19 another bill, seeing a psychologist is one
20 bill, seeing a CASAC is another.
21 We're still not addressing the blended
22 person with holistic treatment and really one
23 bill. Where are we with that? What needs to
24 be done? How close are we? And are there

1 things that the legislative body can do to be
2 helpful?
3 COMMISSIONER SULLIVAN: You know, I
4 think -- you know, we're definitely looking
5 at that. Now, I think -- I believe that the
6 community behavioral health centers that
7 we've established are easier in that respect
8 than some of our other Article 31 providers
9 in terms of the ease with which the billing
10 occurs for the client, for them to experience
11 it.
12 And I think that's the model that we
13 would like to try to use to expand to the
14 other sites. I think that in some of the
15 sites it's gotten a bit better. But yes, we
16 have to work -- it's a combination of working
17 with commercial insurers and depending upon
18 what their desires are, then working with
19 managed care through Medicaid. Sometimes it
20 is difficult to get all the bills straight.
21 We work a lot with the providers about that.
22 So you're right. And we should be
23 working to make sure that that's kind of
24 seamless for the client. I realize that's

1 where we get into trouble here, so the
2 clients get bills.
3 So we will continue to work on that.
4 But the CCBHCs seem to have been able to do
5 this in a more seamless way than some of the
6 others, and we're going to try to use that
7 model to help some of the other centers as
8 well.
9 But yes, there can be difficulties
10 sometimes with getting all the bills
11 organized from multiple providers and
12 insurers.
13 SENATOR HARCKHAM: Great, thank you.
14 Thank you, Madam Chair.
15 CHAIRWOMAN KRUEGER: Thank you.
16 Assembly.
17 CHAIRWOMAN WEINSTEIN: We go to
18 Assemblywoman Miller.
19 ASSEMBLYWOMAN MILLER: Good morning.
20 So I pride myself on being the voice
21 for those who have the quietest voices. A
22 few of the questions that I'm asking have
23 come directly from those voices, people who
24 live in my district or surrounding districts

1 who have serious concerns and have asked me
2 to share.
3 On Long Island this past week there
4 was a ceremony for the opening of a mental
5 health clinic in Rockville Centre. It's a
6 collaboration between Cohen Medical Center
7 and five local school districts. The clinic
8 will provide emergency mental health
9 services, like acutely that day, until a
10 healthcare provider can be located for
11 long-term services. It's needed, and it
12 sounds great.
13 What we're not acknowledging is that
14 this is necessary because there's a shortage
15 of healthcare professionals who have
16 availability in the first place to see these
17 patients. Because most mental health
18 professionals, at least on Long Island, don't
19 accept insurance, the few that do are
20 completely booked. It would be very
21 difficult to find a mental health provider
22 that takes insurance that could fit in a new
23 patient immediately and provide the
24 availability that's needed more than once a

1 week when first treating a patient for a
2 person in crisis.
3 Hospital emergency rooms evaluate
4 pediatric patients with mental health issues
5 to see if they're a danger to themselves or
6 others and, if not, they get referred to
7 long-term-service providers, who can't take
8 them.
9 The clinics, which are collaborations
10 between Cohen and school districts, are
11 needed because there's no place for these
12 pediatric patients with mental health issues
13 to get the immediate attention by medical
14 professionals. But this collaboration is
15 costing each of these school districts
16 $55,000.
17 We all know that our school district
18 budgets cannot sustain this, and they
19 shouldn't have to. There are school
20 districts that are in financial distress. Is
21 it fair that the districts that can squeeze
22 it out of their budget will have that and the
23 school districts that can't afford it
24 shouldn't?

1 Schools should not have to spend
2 $55,000 annually to a hospital for immediate
3 access to mental health professionals for its
4 students. It should be done automatically
5 via our insurance providers or Medicaid.
6 So what can we do about this
7 continuous problem that currently exists
8 where the majority of mental health
9 professionals don't accept insurance? There
10 are months-long waiting periods to get an
11 initial appointment, and they don't accept
12 insurance or Medicaid. If you're lucky
13 enough to have a plan that does allow
14 out-of-network coverage, maybe you can get a
15 percentage of that visit reimbursed. It's a
16 very real obstacle to seeking and receiving
17 treatment.
18 I can tell you that I've experienced
19 this firsthand myself with both my daughter,
20 who experiences anxiety, and my mom, who has
21 Alzheimer's. When my daughter began having
22 panic attacks, we could not find a
23 psychiatrist who could see her for three
24 months. We finally wound up taking her to a

1 crisis center, who prescribed a medication
2 that made her feel worse and recommended
3 therapists for long term, who also didn't
4 accept insurance and had waitlists.
5 For my mother, I'm desperately trying
6 for several months now to find a
7 psychiatrist. My mother, who was herself a
8 clinical psychologist, is very depressed and
9 frustrated by not being able to remember
10 anything and losing her independence. I
11 can't even tell you how many doctors I have
12 called. I've had conversations with these
13 psychiatrists who acknowledge the problem,
14 and they can't schedule an appointment for
15 another two to four months.
16 When I asked what to do if she's
17 having trouble now, I was told to bring her
18 to a crisis center.
19 We are forcing people into crisis by
20 not having the mechanisms in place to help
21 them before they're in crisis. How do we not
22 see that? It's certainly evident in our
23 youth. So how can we start to fix this?
24 COMMISSIONER SULLIVAN: You know,

1 first of all, I'm sorry you've had that kind
2 of difficulty with your family, and I'm sorry
3 for all the families that do.
4 There's a critical issue here that I
5 think has to be faced, and the major one has
6 to do with commercial coverage for mental
7 health and substance use. There's a major
8 problem here, and it's a parity issue. And
9 for a long time commercial insurers have not
10 been covering the kinds of services or
11 covering them with the reimbursement to the
12 extent that is needed to have a workforce
13 willing to take individuals who have
14 insurance.
15 While the Medicaid system is not
16 perfect, there is more access and more
17 availability through Medicaid to get mental
18 health services, often, than through
19 individuals who work and have private
20 insurance.
21 This has been a problem for decades.
22 What the state is doing I think is remarkable
23 in terms of its efforts at this point in
24 terms of parity. The parity, while it will

1 take a little more time to get this to
2 work -- but over the past two years, the
3 state has made a massive investment in
4 parity, and we are getting medical necessity
5 criteria that will be reviewed by the Office
6 of Mental Health. We're looking at networks.
7 Often networks can be phantom networks, which
8 mean that, you know, you look at your
9 insurer, it lists 20 psychiatrists, and you
10 call them all up and they all say they're
11 full or they can't see you or they don't have
12 the time.
13 We are looking at all that. That's
14 all coming through intensive work on the
15 parity side.
16 Now, the important thing about parity
17 is there's a law, but what happened over the
18 years -- the law has been around for like
19 over 10, 12 years -- the enforcement of it
20 has been the issue. And the money that was
21 in last year's budget that will be continued
22 in this year's budget is the money to do that
23 kind of enforcement. What we really need to
24 do --

1 ASSEMBLYWOMAN MILLER: But we can't
2 force a physician to join a plan.
3 COMMISSIONER SULLIVAN: It's not --
4 there are physicians sometimes in the plans
5 that they don't have enough -- you can force
6 the plans to pay enough to get physicians in
7 their plan. That's their responsibility to
8 have physicians available. When you pay your
9 health insurance, if you want a cardiologist,
10 you should be able to get a cardiologist.
11 And if you're in a health plan and you want a
12 psychiatrist, you should be able to get a
13 psychiatrist.
14 So actually the onus on having the
15 network that can provide those services sits
16 with the insurer, and that's where the
17 problem is. For decades mental health
18 services have been underfinanced by those
19 insurers, and that's what has to change. And
20 you have to look at the parity laws, which
21 say how do you determine how you allocate
22 your money, you insurer, how much do you use
23 for behavioral health services, what do you
24 use for others, and how do you ensure that

1 individuals -- when you look across the
2 country, the out-of-network use for mental
3 health services is significantly higher than
4 for any other medical service. Why?
5 Because -- I'm sorry.
6 CHAIRWOMAN WEINSTEIN: Why don't you
7 just finish your sentence.
8 COMMISSIONER SULLIVAN: Because
9 basically the networks are not well
10 established by the insurers. And that's
11 something that the state is working on very
12 hard with parity. It will take some time,
13 but we hope it will significantly affect
14 this.
15 ASSEMBLYWOMAN MILLER: Thank you.
16 CHAIRWOMAN WEINSTEIN: Thank you.
17 Senate?
18 CHAIRWOMAN KRUEGER: Thank you.
19 We've been joined by Senator Betty
20 Little.
21 And next up on deck, Senator Jim
22 Seward.
23 SENATOR SEWARD: Thank you, Madam
24 Chair. And thank you, Commissioner, for

1 being here and for your commitment to some of
2 the most vulnerable citizens of New York, and
3 providing services.
4 I wanted to identify myself with some
5 of the comments of my colleagues already this
6 morning in terms of the salary levels for
7 those that are on the front lines, our direct
8 care workers and other staff of our
9 not-for-profit agencies who provide yeoman's
10 work on behalf of those who are in need of
11 services, and yet, you know, their salaries
12 lag.
13 I know you've mentioned some of the
14 efforts to try to bring them up. Of course,
15 the Legislature has made a major commitment
16 there as well.
17 I wanted to ask you to comment on the
18 Executive's justification for continuing the
19 COLA deferral for the second year and not
20 restoring that in the Executive Budget.
21 COMMISSIONER SULLIVAN: The Executive
22 has introduced the 2 percent targeted salary
23 increases, which occur for direct care
24 support workers in January and then will

1 occur again in April, at 4 percent. Those
2 increases are in the budget and are there.
3 That was in lieu of the COLA last year and in
4 lieu of the COLA this year. And that was an
5 agreement, is my understanding, between
6 various parties including the Legislature
7 last year, that as long as those -- that
8 those targeted salary increases would be this
9 year and last year, and not the COLA.
10 SENATOR SEWARD: I see. The -- there
11 is an advantage of having it run through as a
12 COLA in terms of the long-term stability of
13 their salary levels.
14 COMMISSIONER SULLIVAN: Yes. Yeah.
15 Mm-hmm.
16 SENATOR SEWARD: Shifting gears, we've
17 already discussed the suicide prevention
18 commitment regarding particularly veterans,
19 law enforcement and our first responders. On
20 the positive side, there's an additional $1
21 million in the Governor's proposal to help
22 along that line. Can you comment on when
23 this additional funding will be allocated?
24 And considering that the great need

1 that's out there -- we read it about it
2 practically every day -- it's important that
3 this funding be disbursed as soon as
4 possible. And I would also -- as you look to
5 the distribution of these funds, I would urge
6 you to look toward regional balance of the
7 funding distribution because we have many
8 needs in the upstate region. In many ways
9 it's even more serious, because of the
10 distances involved.
11 So if you could comment on when these
12 funds will be available and also on the
13 regional allocation.
14 COMMISSIONER SULLIVAN: Yeah, we're
15 going to try to move these funds as quickly
16 as possible. It's not so much, I don't
17 think, the availability of the funds as the
18 planning to how to use them. And I think
19 that's going to take a little time -- a
20 couple of months, probably -- working with
21 law enforcement, working -- we're going to be
22 working with our state troopers across the
23 state, we're going to be working with
24 veterans as well -- this is for veterans and

1 first responders -- and with various EMS
2 teams across the state, to discuss where is
3 it most needed. Many -- for example, state
4 troopers already do some work in this area.
5 But where are the gaps? What are the things
6 where we need to enhance? And what should a
7 media campaign look like?
8 And when you talk about working with
9 getting -- decreasing stigma, it's often very
10 local, just as you said. You know, the same
11 approach to working with the community in
12 rural upstate New York or middle New York
13 versus, you know, Long Island, it's very
14 different. So we have to really plan out how
15 we're going to use -- so there's going to be
16 some time for planning. I don't think it's
17 the allocation, so much, of the funds as
18 making a plan sufficiently in-depth and with
19 the right people to advise us as to how to do
20 it. And that will take a few months to do.
21 So we're hopeful we'll be able to have
22 something by the summer that will be, you
23 know, able to begin to be launched.
24 SENATOR SEWARD: Thank you.

1 Just one final question. I know
2 you're familiar with the Joseph P. Dwyer
3 Veteran Peer-to-Peer Program. OMH staff has
4 been invaluable in planning and
5 implementation of these programs. And this
6 has been a long-term commitment and priority
7 of the Senate, and I'm pleased that that
8 continues under the new majority as well.
9 And can you comment on the
10 effectiveness of this program, the Dwyer
11 Peer-to-Peer? And also, considering the
12 importance of this program, why isn't there
13 any funding in the budget proposal to
14 continue this?
15 COMMISSIONER SULLIVAN: The Dwyer
16 program has traditionally been funded through
17 a legislative add, and it is in this budget
18 as well.
19 As a program, it is -- yes, it's been
20 shown to be very effective. It's a peer
21 program, as you well know, where vets talk
22 with vets. And I think that's probably been
23 shown across the board to be one of the most
24 effective ways to reach veterans, others in

1 law enforcement, et cetera.
2 So it's a good program, it's a solid
3 program, but it has traditionally been funded
4 by legislative adds.
5 SENATOR SEWARD: Thank you.
6 CHAIRWOMAN KRUEGER: Thank you.
7 Assembly.
8 CHAIRWOMAN WEINSTEIN: We go to
9 Assemblywoman Walsh.
10 ASSEMBLYWOMAN WALSH: Thank you.
11 Good afternoon, Commissioner. I've
12 been an attorney for 30 years, and a good
13 part of that has been working in Family
14 Court. For a while I prosecuted abuse and
15 neglect cases, and a great, great number of
16 cases in my caseload involved sexual
17 offenders, sex offenders and intrafamily
18 sexual abuse.
19 So I wanted to ask you about the Sex
20 Offender Management and Treatment Act, SOMTA,
21 and reform in that program. Can you explain
22 how your proposed Sex Offender Management and
23 Treatment Act reforms are going to be carried
24 out?

1 COMMISSIONER SULLIVAN: Yes. The Sex
2 Offender -- the SOMTA programs are for those
3 individuals who are leaving prison who have
4 been civilly committed to -- now to the SOMTA
5 program. The average stay in that program is
6 something like five years, so most of the sex
7 offenders are very serious, high-level sex
8 offenders.
9 When the legislation was first passed,
10 it was done under the auspices of a
11 hospital-based approach. And the science in
12 terms of working with this population, as
13 well as our experience over the past years,
14 has been that basically you want more of a
15 psychosocial rehab approach, which helps
16 people change hopefully their behaviors which
17 have led to the sex offender status.
18 So we're really redefining
19 programmatically what's going to be
20 happening. To do that and do it well, you
21 needed to kind of move the auspices under
22 something called secure treatment and
23 rehabilitation in order to, for example, hire
24 more psychologists, hire more -- others who

1 are skilled at a certain level of treating
2 that particular population.
3 And we're hopeful that by redesigning
4 it, we can even be more successful. We've
5 been able -- some individuals have been able
6 to leave, very slowly, very carefully, back
7 into the community. And we're hopeful that
8 working with this new model will be even more
9 effective. Currently there's about 385
10 individuals in civil commitment.
11 ASSEMBLYWOMAN WALSH: Okay. And will
12 these reforms involve the movement of
13 patients from one facility to another, or
14 will patients be just segregated in their
15 current facility?
16 COMMISSIONER SULLIVAN: They will stay
17 exactly where they are. They will stay in
18 the same facilities, the same degree of
19 security -- everything will be the same.
20 It's really just the clinical programming
21 that's shifting, not the location or the
22 legal status. It's the same.
23 ASSEMBLYWOMAN WALSH: And as I said
24 before, you know, my experience told me that

1 sex offender treatment is some of the most
2 difficult treatment that's out there. It's
3 very, very difficult to break that cycle. So
4 are patients going to be getting any new
5 treatment that they're currently not getting?
6 COMMISSIONER SULLIVAN: It will be
7 more focused on what we call a psychosocial
8 rehab approach -- more groups, more ability
9 to work really on the -- on learned behaviors
10 which you're trying to unlearn. And more
11 focused on cognitive kind of work.
12 So yes, it will be an enhancement of
13 what they're currently receiving, we believe
14 while being able to move to a certain level
15 of expertise with the clinicians that will be
16 in that program.
17 ASSEMBLYWOMAN WALSH: And when do you
18 think that that new approach is going to be
19 effective, taking effect?
20 COMMISSIONER SULLIVAN: Well, we'll
21 start on -- if the legislation is passed,
22 we'll begin right away. And probably it will
23 take a while to do all the training and
24 things that are necessary. But I would give

1 it six months to nine months, we should have
2 in place the changes, and then we'll evaluate
3 them.
4 As you have said, this is a very
5 thorny issue and we are trying to really
6 provide the best evidence-based practices for
7 individuals in the sex offender treatment
8 program, but that is a very difficult group
9 to treat.
10 ASSEMBLYWOMAN WALSH: Thank you.
11 CHAIRWOMAN KRUEGER: Thank you.
12 Senator Luis Sepúlveda.
13 SENATOR SEPÚLVEDA: Good morning,
14 Commissioner. Thank you, Madam Chair.
15 Commissioner, as you may or may not
16 know, the issue of suicide is very personal
17 to me. When I was 11 years old, my mother
18 committed suicide. She suffered from mental
19 illness, and unfortunately back then 40 years
20 ago, 45 years ago, we didn't have the
21 services that we have today.
22 But her manifestation started when she
23 was a child. According to mental health
24 advocates, 54 percent of children with mental

1 health or behavioral conditions that needed
2 treatment in the last year did not receive
3 treatment. Additionally, suicide is the
4 second leading cause of teenagers between 15
5 and 19. Amongst Latinas, it's the second
6 leading cause; amongst African-American young
7 boys, same amount. Over 40 percent of the
8 LGBTQ community also has considered suicide
9 or engaged in suicide ideation.
10 In 2011 the original Medicaid Redesign
11 Team found that children's mental health
12 services need more resources and capacity and
13 should not be cut. Nine years later, the
14 Children's Behavioral Health MRT Subcommittee
15 is still working to implement reforms that
16 will expand children's mental health,
17 addiction and care coordination services.
18 So my first question is, should there
19 be a moratorium on children's mental health
20 cuts while the full reform and transition to
21 Medicaid managed care is going on?
22 COMMISSIONER SULLIVAN: There are no
23 projected at this point in time. That
24 reduction in the rate that was there for

1 start-up -- I explained that -- has been
2 reduced. But the overall plan, which
3 includes those services being expanded to
4 serve even more youth going forward, is still
5 in place, and the commitment to continue that
6 expansion of services, which at various
7 points has been estimated to be an additional
8 30 to 60 million over the next couple of
9 years as these services expand.
10 The newer services are very
11 community-based home-based services, and they
12 include things like psychiatric home-based
13 services, other licensed providers being able
14 to go into the home. All these services are
15 now being started up and are growing. As
16 they grow, they are expected to increase the
17 services for youth, especially youth at high
18 risk that need intensive services.
19 So at this point in time the growth of
20 that program, which is what -- the way it was
21 planned through the MRT and the way all those
22 services were provided, is continued. And
23 the investment in that is still in place.
24 SENATOR SEPÚLVEDA: So there haven't

1 been any cuts, or there are no projected
2 cuts?
3 COMMISSIONER SULLIVAN: No, there has
4 been a cut -- there has been a reduction, a
5 planned reduction, which was always there,
6 for the start-up dollars. Which was supposed
7 to only last a year. So those dollars, yes,
8 have been reduced and have stopped as of
9 January 1st.
10 But the overall program is still
11 embedded into the Medicaid dollar.
12 SENATOR SEPÚLVEDA: Well, I will
13 strongly encourage and implore you not to cut
14 any -- at any level, because, you know, we
15 have to start at the -- when they start
16 manifesting mental health issues at a young
17 age and we don't treat it, any cut to me, I
18 think, is unacceptable.
19 And then will the work of the
20 Children's Behavioral Health MRT Subcommittee
21 be addressed by MRT II? Or will MRT II be
22 asked to defer to the ongoing work of the
23 children's subcommittee without any sort of
24 inference?

1 COMMISSIONER SULLIVAN: Basically
2 those plans are still being discussed, so I
3 can't answer that at this time.
4 SENATOR SEPÚLVEDA: They're still
5 being discussed?
6 COMMISSIONER SULLIVAN: Yeah.
7 SENATOR SEPÚLVEDA: And when do you
8 think --
9 COMMISSIONER SULLIVAN: The -- I'm not
10 sure. Within the next several weeks when
11 various other things are decided about the
12 MRT.
13 SENATOR SEPÚLVEDA: All right. So I
14 can follow up with you on that once we have
15 further information.
16 COMMISSIONER SULLIVAN: Yes. I'll be
17 glad to follow up with you, yes.
18 SENATOR SEPÚLVEDA: So now my next
19 question is really based as the chair of
20 Corrections. In the past budgets you've
21 proposed getting rid of 50 mental health beds
22 devoted to jail-based competency restoration,
23 and the Legislature has outwardly rejected
24 it. Are you again proposing to close 50

1 beds?
2 COMMISSIONER SULLIVAN: We're
3 proposing jail-based restoration, which would
4 basically enable a county to decide to do
5 restoration to competency, the ability to
6 stand trial. In a jail, versus having to
7 transfer that person by statute to a
8 hospital. Basically saying based on medical
9 necessity.
10 You can do outpatient restoration for
11 individuals who are not in the prison or jail
12 system. So outpatient restoration is
13 something that can be done. And what we're
14 proposing is that that outpatient restoration
15 be done in an appropriate program which will
16 be staffed appropriately, followed on the
17 best practices in other states.
18 So the jail-based restoration, what it
19 basically does, it enables individuals to be
20 closer to home and to get the services they
21 need in the jail without having to be
22 transported for competency to a hospital if
23 that's not medically necessary that they go
24 to a hospital.

1 SENATOR SEPÚLVEDA: I've seen some
2 examples of that in some of the facilities,
3 and I'm completely dissatisfied with what
4 I've seen. I don't think that the services
5 that are provided are adequate in
6 Corrections.
7 COMMISSIONER SULLIVAN: Well, just to
8 say there is no other jail-based restoration
9 at this point, though. This would be a
10 distinctive program, that's all.
11 SENATOR SEPÚLVEDA: Right. But in
12 facilities where they actually provide or
13 attempt to provide --
14 COMMISSIONER SULLIVAN: Yes, that's a
15 different issue, yes.
16 SENATOR SEPÚLVEDA: -- mental health
17 services, I think it's been a complete
18 disaster. And I've spoken with providers for
19 this; there's not enough money, there's not
20 enough services. And so that's another issue
21 that I think we should have a discussion
22 about.
23 COMMISSIONER SULLIVAN: Okay. Glad
24 to.

1 SENATOR SEPÚLVEDA: Thank you.
2 CHAIRWOMAN KRUEGER: Thank you.
3 Assembly?
4 CHAIRWOMAN WEINSTEIN: We go to
5 Assemblyman Ra for a question.
6 ASSEMBLYMAN RA: Thank you.
7 I just wanted to ask about -- I know
8 there is an increase of $12.5 million for new
9 adult home beds, beds and services, in the
10 Aid to Localities budget proposal. Is there
11 any information on where those might be
12 located in the state?
13 COMMISSIONER SULLIVAN: The adult home
14 beds are connected to an adult home
15 settlement, which by and large is New York
16 City. So they're tied to a legal settlement
17 and geographically. So those particular
18 adult home beds are locked in. And they're
19 primarily in New York City.
20 ASSEMBLYMAN RA: Okay. Thank you.
21 CHAIRWOMAN WEINSTEIN: So we go back
22 to the Senate now.
23 CHAIRWOMAN KRUEGER: Thank you.
24 Senator Borrello.

1 SENATOR BORRELLO: Thank you, Madam
2 Chair, appreciate it.
3 And thank you, Commissioner Sullivan,
4 for being here today. It's nice to meet you
5 in person after talking on the phone several
6 times.
7 And first of all, let me say thank you
8 very much for your involvement and your
9 team's involvement with a critical issue
10 we're having in my district with Lake Shore
11 Hospital. And it leads to my question,
12 particularly on mental health services in
13 rural areas.
14 You know, we are now facing a shortage
15 of beds throughout the state, yet the closure
16 of Lake Shore Hospital is going to see the
17 decommissioning of 20 critically needed beds
18 in that region. On top of the other
19 challenges we face, my question is is that it
20 appears to me -- as a former county executive
21 and a person who lives in that immediate
22 area, it appears to me that the Department of
23 Health and OMH were not in coordination on
24 this. The left hand of state government

1 doesn't know what the right hand of state
2 government is doing. And we have a crisis in
3 our rural communities when it comes to mental
4 health services. And yet we are closing beds
5 unnecessarily. And DOH is being myopic in
6 their view of the services -- the holistic
7 view that's required of the services that are
8 really critically needed in our area.
9 So my question to you is how can we
10 justify allowing beds to be decertified, and
11 what can be done to preserve those and ensure
12 that in the long run that DOH and OMH are
13 coordinating their efforts to provide vital
14 healthcare services to our regions,
15 especially in the rural areas?
16 COMMISSIONER SULLIVAN: Thank you.
17 You know, we work very closely with DOH on
18 these issues and on the complement of beds
19 that are needed for a particular area, both
20 on the mental health side and obviously DOH
21 is concerned on the medical side as well.
22 I think that, you know, it's just a
23 historic fact that psych beds, mental health
24 beds do not have the financial margin, by and

1 large, that other medical beds have. So
2 sometimes hospitals decide that, you know,
3 for financial reasons they need to lower
4 psych beds. That's always a serious issue,
5 because we don't have as many as we might
6 need, and we need to work very closely with
7 those hospitals to make sure that there's
8 enough services in the area.
9 And that's what we're trying to do in
10 the area which will be impacted by TLC. And
11 we are looking to see where we might be able
12 to grow other kinds of services. Sometimes
13 hospitals have been very helpful, even if
14 they close beds, in establishing more
15 outpatient ambulatory services. So we always
16 work with communities to try to make this
17 happen. Sometimes hospitals move quickly on
18 this, quicker than we want them to, before
19 plans are available, and then we -- sometimes
20 we resort to regulatory responses to that.
21 But the reality is that we have always
22 worked very hard and worked together across
23 the state to try to provide the services that
24 communities need.

1 SENATOR BORRELLO: Let me compliment
2 you on the work that you have done to help.
3 But unfortunately the coordination with DOH
4 wasn't good. You worked very hard to help us
5 try to overcome this situation, but at the
6 end of the day it appeared DOH was singularly
7 minded in wanting to close that hospital and
8 really deny those services to their area.
9 And they gave their closure approval without
10 OMH's approval, which is just, you know, I
11 think unforgivable in that sense. There just
12 needs to be better coordination, especially
13 the fact that we have a crisis in healthcare
14 in our rural areas. And it just seems that
15 there was -- you know, DOH moved forward
16 without OMH's, you know, collaboration and
17 approval, clearly. And having that happen
18 again -- you know, this time it's the
19 hospital in my area. Next time it's going to
20 be somebody else's hospital. And it seems to
21 be, you know, not -- it's focused on dollars
22 and cents and not on the needs of the people.
23 And that is a real issue.
24 Thank you.

1 COMMISSIONER SULLIVAN: Thank you.
2 CHAIRWOMAN KRUEGER: Assembly.
3 CHAIRWOMAN WEINSTEIN: We go to
4 Assemblywoman Gunther.
5 ASSEMBLYWOMAN GUNTHER: So I have a
6 few questions. The Executive has proposed
7 removing pre-admission certification
8 committees to determine a child's need for
9 residential treatment. What will the role be
10 of a newly created advisory board within the
11 Council of Children and Families?
12 COMMISSIONER SULLIVAN: I think that
13 the new advisory board will help us not just
14 with admission criteria and census,
15 et cetera; they'll help us with the design, I
16 believe, of the RTF system.
17 The Council on Children and Families
18 is a very active council, and I think they
19 can talk with us about the needs of
20 communities and the kinds of design that we
21 need in these facilities. By changing the
22 PACC admission process, it also gives us the
23 flexibility to do some creative work with the
24 RTFs across the state. And in particular,

1 many of the upstate RTFs are particularly
2 happy with this change because it gives more
3 flexibility in both admissions -- the kinds
4 of admissions and the kinds of services that
5 can be provided.
6 So we think it's a really good move,
7 and many of the upstate groups such as
8 Northern Rivers and Parsons are very involved
9 and are very happy that we've modified the
10 PACC admission process.
11 ASSEMBLYWOMAN GUNTHER: Can you give
12 me examples of what type of behavior would
13 lead to the insurer being fined?
14 Also, regarding children's behavioral
15 rates, you say that you have start-ups. But
16 when did they actually begin?
17 COMMISSIONER SULLIVAN: Excuse me, an
18 individual's being fined, is that relative to
19 parity?
20 ASSEMBLYWOMAN GUNTHER: Yes.
21 COMMISSIONER SULLIVAN: Yes. Well,
22 there will be regulations that will be posted
23 as of October of this year which will clearly
24 outline in great detail the various kinds of

1 things that insurers must respond to, and
2 they could possibly lead to fines. So that
3 compliance program is in this year's budget.
4 And it's stated that basically as of October
5 we'll have those regulations out, which will
6 make it even clearer what can lead to what
7 kind of repercussions if you're not following
8 the parity regulations.
9 At this point in time we have already
10 received all the medical necessity criteria
11 from the various insurers, we're reviewing
12 them, and how the compliance program will be
13 set up to make sure that they do it should be
14 established by October. And then we'll see,
15 as a result of those regulations, what the
16 fines will be kind of connected to that.
17 ASSEMBLYWOMAN GUNTHER: So I think
18 there was about 1.5 million. Where did the
19 money go?
20 COMMISSIONER SULLIVAN: No, that
21 hasn't happened yet. I mean, there was an
22 estimate that that might be the level. If
23 that money were to occur.
24 ASSEMBLYWOMAN GUNTHER: So where would

1 it go, then?
2 COMMISSIONER SULLIVAN: It would go to
3 the ombudsman program, the CHAMP ombudsman
4 program, which would then use that money to
5 further the efforts of parity, educating
6 families dealing with denials, et cetera. If
7 it occurs.
8 ASSEMBLYWOMAN GUNTHER: You also --
9 the other thing is like with the rates for
10 housing. So the new stock, they get an
11 increased rate, where old stock, they don't
12 get the same amount of money for their
13 rentals for people --
14 COMMISSIONER SULLIVAN: The 20
15 million, though, is going towards older
16 housing which is already there, all types of
17 housing. In the past sometimes we've limited
18 it to specific housing; now it's any kind of
19 housing can be eligible for that $20 million,
20 and it will also be spread across the state.
21 ASSEMBLYWOMAN GUNTHER: Okay. Thank
22 you.
23 CHAIRWOMAN WEINSTEIN: Senate?
24 CHAIRWOMAN KRUEGER: Thank you.

1 Senator Akshar.
2 SENATOR AKSHAR: Madam Chairwoman,
3 thank you.
4 Commissioner, always good to see you.
5 Let me go specifically to the Greater
6 Binghamton Health Center. Are there any
7 conversations happening about a reduction in
8 beds, either adult beds or children beds?
9 COMMISSIONER SULLIVAN: No.
10 SENATOR AKSHAR: Good. That's good
11 news. Thank you.
12 Let me move, if I may, to mental
13 health services in the public school system.
14 What type of money are we investing as a
15 state to address that issue? It's an issue,
16 at least from my perspective, that is at
17 crisis levels. Any school superintendent you
18 speak to will tell you that they are dealing
19 with mental health crises on a daily basis.
20 So what is our investment to deal with
21 that statewide?
22 COMMISSIONER SULLIVAN: One of the
23 major initiatives is to increase the number
24 of school-based mental health clinics, which

1 we've been successful in doing. What you do
2 is you work with a community-based provider
3 who then works with the school to set up a
4 satellite in that school, on site. Usually
5 it's a social worker, but also now some of
6 these are also using telepsychiatry to beam
7 in psychiatrists to work in the school, and
8 they can provide the services on site.
9 That has worked in 800 schools so far,
10 and we're working with all the school
11 districts to increase that.
12 In addition, the work which is done by
13 the Mental Health Education Act, in
14 conjunction with the schools, has set up an
15 entire ability to begin to look at the
16 social/emotional wellness from early on in
17 the schools, from kindergarten through
18 12th grade. So all the work on curricula, et
19 cetera, is something which is also jointly
20 done by the Department of Ed and also by
21 Mental Health.
22 In addition, we do lots of crisis
23 trainings in schools, lots of suicide
24 prevention in schools. We have a whole

1 suicide prevention plan -- guidelines which
2 we just printed as of about a month ago and
3 we're distributing to all these schools as to
4 how to set up a tiered approach to working
5 with possible suicide issues in their
6 schools. And we're available for all kinds
7 of technical assistance with them.
8 We've also done some pilots of some
9 very intensive work in schools, including
10 something called ParentCorps, which works
11 with the pre-K population and does parent
12 teaching for schools. It's limited, but it's
13 something that we are looking at to see if it
14 might possibly grow.
15 And we also have, across the state in
16 some schools -- five districts in the state,
17 most of them upstate -- called Promise Zones,
18 where there's an investment in dollars that
19 come to the schools to come together with
20 community-based providers so that schools not
21 only have clinics on-site, but they also
22 understand all the community-based services
23 that are available and work in partnership.
24 So there's a number of initiatives

1 going on across the state. But the mainstay
2 is trying to get more and more satellite
3 clinics into schools. Because they not only
4 -- they see individual kids, they work with
5 teachers, they help educate the teachers,
6 they help work together to solve problems.
7 So that's probably one of the most effective
8 ways to help the schools.
9 SENATOR AKSHAR: Could you quantify,
10 though, in dollars what we're investing in
11 the public school system to address the
12 issue?
13 COMMISSIONER SULLIVAN: I don't know
14 if I could give you the exact dollars. I
15 could work on that to give you how all these
16 things add up. But I don't have it kind of
17 off the top of my head exactly what that
18 would be.
19 But I'll get back to you, Senator.
20 SENATOR AKSHAR: Let me ask you I
21 guess a more direct question. Do you think
22 the investment that we're making in the
23 public school system is significant enough to
24 address the underlying issue?

1 COMMISSIONER SULLIVAN: I think -- you
2 know, in some ways you can always do more. I
3 think this is a very, very strong beginning.
4 I really do believe that on-site work -- you
5 know, there's a lot that can be done with
6 trainings and education. But on-site
7 availability I think is one of the most key
8 things.
9 Many years ago I had a school-based
10 program when I worked in Queens, and
11 basically it was marvelous the difference it
12 made in a very troubled junior high school.
13 So I think that on-site capacity is
14 really critical, and so we're putting a lot
15 of our energies into getting that available,
16 so that when you're in a school and you have
17 a youth that you might be concerned about,
18 you have someone you can consult with, go to
19 them, get some feedback, help them get the
20 services.
21 So that's -- we're doing that. We're
22 doing all the other things too, but I think
23 that's a critical piece.
24 SENATOR AKSHAR: So I just want to

1 thank you publicly for all the work that you
2 are doing in the initiatives that you speak
3 about.
4 But we're falling short as a state.
5 This is not -- this is not a knock on you or
6 anybody who works in your office, because I
7 believe in my heart that you're doing the
8 very best you can with what resources you
9 get. But for me this comes down to wants
10 versus needs.
11 When I look at the Joseph P. Dwyer
12 program, the investment, $3.7 million, it's a
13 remarkable program, but that's a paltry
14 investment. Last year there was a
15 million-dollar grant provided for schools to
16 compete against one another to address some
17 of their mental health issues.
18 You know, nobody knows the scope and
19 the difficulties of providing these services
20 better than you and the people that work for
21 you. I would argue that we are really at a
22 crossroads in this state. And when I see the
23 Executive make a suggestion that we would
24 invest $300 million in the restoration of the

1 Erie Canal, but yet only invest $3.7 million
2 in a program like Joseph P. Dwyer or have to
3 fight over dollars to provide mental health
4 services in schools, again, I think we're
5 falling short and we need to do a much better
6 job.
7 Madam Chairwoman, thank you for the
8 time.
9 CHAIRWOMAN KRUEGER: Thank you.
10 Assembly.
11 CHAIRWOMAN WEINSTEIN: We've been
12 joined by Assemblywoman Buttenschon,
13 Assemblyman Weprin.
14 And we go to Assemblywoman Miller for
15 a question.
16 ASSEMBLYWOMAN MILLER: Hi again. For
17 the behavioral health ombudsman, where is the
18 funding coming from for that? Is it coming
19 from the penalties that are deposited to the
20 fund? And if that's the case -- I'm just
21 jumping the gun -- if that is the case, does
22 the ombudsman start or does it have to wait
23 for the program to get funded from that --
24 COMMISSIONER SULLIVAN: Sorry. It was

1 actually started last year. There was an
2 allocation in the budget last year for 1.5
3 million for the ombudsman program. They've
4 already seen about 1600 clients and I think
5 have done 5,000 educational -- so they've
6 done a lot of work.
7 If fines are levied, that's additional
8 dollars that would then go in addition, on
9 top of the base funding, which is 1.5
10 million.
11 ASSEMBLYWOMAN MILLER: Thank you.
12 CHAIRWOMAN WEINSTEIN: Senate.
13 CHAIRWOMAN KRUEGER: Senator Sue
14 Serino.
15 SENATOR SERINO: Hello, Commissioner,
16 and thank you for being here today.
17 This is always a very sensitive
18 subject to me; I lost my brother by suicide
19 10 years ago, and I've been very open about
20 speaking about it from the time of his
21 obituary and trying to get rid of that
22 stigma.
23 And I know in 2018 we had passed a
24 bill that was -- not passed, I'm sorry, we

1 introduced a bill that would establish the
2 mental health services program coordinator
3 that would reimburse the schools for hiring
4 these professionals. And I know Senator
5 Akshar had spoken about that, and you
6 mentioned that there are 800 schools that
7 have some type of a pilot or a program.
8 But I know in my district I'm hearing
9 from kids -- and it doesn't matter if it's in
10 a wealthy school district, a poor school
11 district, middle class, they're all saying
12 that they're not getting enough help. And I
13 know that we don't have the beds for our
14 children too. Nobody wants to go into a
15 lockdown emergency services facility and then
16 -- you know, it's kind of scary, especially
17 for a kid, and then to think that they're
18 going to go back there again.
19 So I just wonder, you know, where
20 those 800 schools are, because I'm not seeing
21 it in my district.
22 COMMISSIONER SULLIVAN: They're spread
23 across the state. There are more of them
24 upstate, actually, than downstate. But I can

1 get you exactly how many might be in Staten
2 Island. I'm not sure off the top of my head
3 which ones, but there are several -- not
4 several, there's a number in the city,
5 probably about 25 to 30 percent in the city
6 and the rest are upstate.
7 We've been working with the Department
8 of Ed in the -- trying to work with the
9 Department of Ed in the city to kind of
10 foster more ability to have mental health
11 clinics in the schools. But I can -- I'll
12 definitely get to you on what's available in
13 your district.
14 SENATOR SERINO: Thank you. And I
15 liked hearing about the telepsychiatry too.
16 I think it's great, especially when you live
17 in a rural community. As far as seniors, you
18 know, we have a lot of seniors that suffer
19 from social isolation. And is there anything
20 that you're doing with the telepsychiatry for
21 our aging seniors? I'm the ranker on the
22 Aging Committee and was wondering -- I'm just
23 joining the mental health committee now, so
24 I'm just wondering if there are any services

1 for the seniors as well.
2 COMMISSIONER SULLIVAN: There's a
3 mental health association in upstate New York
4 that has done a little bit of a pilot with
5 the elderly in terms of a telegroup where --
6 dealing with the issue of social isolation,
7 where people can get together, talk via --
8 they're a combination of tablets and
9 computers -- with a great deal of success.
10 So we're looking into that in terms of
11 some of the approaches that we have with the
12 elderly. Social isolation is a huge issue,
13 by and large, and we're probably not using
14 technology the way we should be. So that
15 whole -- telemedicine is something that we
16 have significantly expanded the ability to do
17 and to bill for. Now I think we have to get
18 the word out there and get creative about how
19 we use it.
20 And I think that one of the creative
21 ways can be, you know, kind of group therapy
22 through -- which now could be reimbursed by
23 Medicaid, we're still working sometimes with
24 the commercial insurers. But you could do

1 that for the elderly across a group.
2 So we'll definitely be expanding that.
3 And I thinking that that really is a big
4 piece of the future. And it's also a way to
5 increase access and to deal with the
6 workforce limitations. So there's a great
7 deal that can be done with that.
8 SENATOR SERINO: That's very
9 encouraging.
10 And then I just want to echo the
11 sentiments that my colleagues have mentioned
12 about the Dwyer, the Peer-to-Peer Program.
13 We first received it my first year in the
14 Senate, and it's been wonderful working
15 through Mental Health America, through the
16 county. It's just great. And I wouldn't
17 want to see any additional money that's put
18 in the budget for mental health -- you know,
19 like not robbing from Peter to pay Paul.
20 It's bad enough that our guys have to
21 come up here every single year and kind of --
22 you know, they schlep up here and they beg
23 for that money for the Dwyer program, where
24 we -- and I know that that's not you, but

1 it's where -- you know, we keep fighting for
2 it, and I don't want to see the extra money,
3 the million dollars that are going to help
4 our law enforcement, first responders,
5 everybody for mental health, you know, be
6 taken, you know, one for the other. I think
7 it's all vitally important.
8 Thank you.
9 CHAIRWOMAN KRUEGER: Thank you.
10 CHAIRWOMAN WEINSTEIN: I have a couple
11 of questions. But before that, just wanted
12 to say that we've been joined by
13 Assemblywoman Carmen De La Rosa.
14 And I want to switch to a question
15 about jail-based restoration. So the
16 Executive Budget includes 1.7 million in net
17 savings related to the development of
18 specialized beds in local jails to restore
19 felony-level defendants to competency. And
20 I'm wondering if you might comment or if you
21 know the fiscal impact on jail based -- that
22 this jail-based restoration would have on
23 counties, since they'd now be required to pay
24 100 percent of the cost beginning on April 1.

1 Are the counties both financially able
2 to take on that responsibility, and do we
3 have any concern about how the -- now that
4 the counties would be doing this, how it
5 would affect the quality of services provided
6 within the local jails?
7 COMMISSIONER SULLIVAN: The counties
8 are currently paying 50 percent of the cost
9 of hospital-based restoration, which is about
10 $130,000 a year. So it's quite high, because
11 it's hospital-based care and treatment. When
12 it goes to 100 percent, that would be
13 $130,000 for -- pretty much the cost per
14 restoration to competency.
15 Jail-based restoration is about a
16 third of that cost. So jail-based
17 restoration would leave probably a cost to
18 the counties of about 35,000 to 40,000 per
19 jail-based restoration. So that's one of the
20 incentives perhaps to do jail-based
21 restoration.
22 The problem here is that
23 individuals are getting hospital-based care
24 for restoration when they really kind of only

1 need outpatient level of care. And so the
2 counties are paying a very high cost even
3 now, and it will get higher with the 100
4 percent cost.
5 CHAIRWOMAN WEINSTEIN: Thank you for
6 that response.
7 Senate?
8 CHAIRWOMAN KRUEGER: Thank you.
9 Second time, David Carlucci.
10 SENATOR CARLUCCI: Great. Thank you,
11 Chair.
12 Thank you, Commissioner, for your time
13 today. I'll try to be as brief as possible.
14 I just had a few more points I wanted to go
15 through with you.
16 First, the streamlining preadmission
17 process for residential treatment facilities,
18 it looks like we're going from a 30-day wait
19 to 15 days, which looks good on paper. I
20 just want to hear from you how we safeguard
21 this process and make sure that it's actually
22 working to the extent of what we have here on
23 paper.
24 COMMISSIONER SULLIVAN: We're going to

1 be monitoring it very closely. The
2 individuals who -- there will still be a
3 review by a physician who will be designated
4 by me to kind of take a look at those
5 admissions and make sure. But we should be
6 able to reduce the time drastically because
7 prior it required a number of committee
8 steps, you had to have a group meet, which
9 only met once a month. I mean, that's now --
10 there will be timely meeting, there will not
11 be this once-a-month meeting, you can get a
12 review done in a day or two so that we can
13 get the information back.
14 So it should streamline the process,
15 but we're going to be monitoring it very
16 closely to make sure. I think it will be
17 less than two weeks, but we're targeting, to
18 be sure, two weeks.
19 SENATOR CARLUCCI: Yeah, I hope so.
20 Well, thank you.
21 And then back to the jail-based
22 restoration program, I know last year the
23 Governor had put this in the Executive
24 Budget. But the difference is -- same

1 proposal as this year, but the Governor was
2 offering money to the localities that opted
3 into this program.
4 I'm concerned for a few reasons.
5 First, that we're putting in a $1.7 million
6 savings into the budget. And it looks like
7 the Governor is anticipating that
8 municipalities will join onto this program.
9 The concern I have is that -- and I'll let
10 you answer. My concern is that
11 municipalities will not opt into this program
12 because there's no dollars coming forth to
13 make the upgrades necessary to meet these
14 needs.
15 Can you speak to the jail-based
16 restoration program and how you see it making
17 those savings? And have any municipalities
18 expressed interest? Are any municipalities
19 ready to go with no additional funding?
20 COMMISSIONER SULLIVAN: There are some
21 municipalities who have expressed interest.
22 No one has said at this point this year that
23 they are ready to start, partly -- the one
24 municipality that had been, in the past,

1 wanted to just wait and kind of think about
2 it again because of some of the changes.
3 But jail-based restoration would
4 basically reduce the cost to the counties of
5 what they were paying now and will pay in the
6 future to have inpatient hospital
7 restoration.
8 Yes, there would be some start-up that
9 might be needed in terms of getting this
10 started in the counties, but that should be
11 not that much. And basically, even without
12 the additional dollars which were there in
13 the year before, which were really startup
14 dollars -- even without those dollars, it
15 should still be financially in the interest
16 of the counties to do this because the cost
17 of inpatient hospital-based restoration is so
18 high.
19 And this would only be for counties
20 that were big enough to have a large enough
21 population that would benefit from this.
22 SENATOR CARLUCCI: So the $1.7 million
23 in savings -- that's savings to the State of
24 New York -- what now is the cost? Do we bill

1 the municipalities for that psychiatric care
2 when an inmate is unable to -- when they are
3 referred to the psychiatric facility? What
4 type of reimbursement are we talking about?
5 COMMISSIONER SULLIVAN: The average
6 cost is a thousand dollars a day in a
7 hospital. And the average time -- that's
8 average time, so for some it could be more or
9 less -- is about three -- almost four months,
10 almost 140 days to restoration to competency.
11 So the actual dollars is close to -- on
12 average, is about $140,000 which counties
13 would now be paying, per restoration, to the
14 state.
15 SENATOR CARLUCCI: What is currently
16 happening? When they send someone to the
17 facility, is the state rebilling the county
18 for that?
19 COMMISSIONER SULLIVAN: Currently,
20 yes. The county gets billed currently
21 50 percent. In New York City they have been
22 billed for the past year also at a hundred
23 percent.
24 Going forward, the counties would be

1 billed -- all counties would be billed for a
2 hundred percent.
3 SENATOR CARLUCCI: So, wait, what is
4 it now?
5 COMMISSIONER SULLIVAN: Right now this
6 year -- prior to this year, counties were
7 paying 50 percent of the cost of the
8 hospital-based restoration, which is about --
9 which was about $70,000 per restoration. If
10 you -- but New York City, as of last year,
11 was paying a hundred percent of the cost.
12 Going forward, all counties will pay a
13 hundred percent of the cost of the
14 hospital-based restoration.
15 SENATOR CARLUCCI: And why is New York
16 City excluded from this proposal?
17 COMMISSIONER SULLIVAN: They're --
18 they -- there wasn't any interest at the time
19 in New York City. And partly it's the way
20 they are established, the way they have
21 pre-arraignment hospital -- the way they're
22 established doesn't really fit for the need
23 for jail-based restoration. It really is a
24 program that is best-served upstate.

1 SENATOR CARLUCCI: Thank you,
2 Commissioner.
3 CHAIRWOMAN KRUEGER: Thank you.
4 The Assembly is done. I'm just going
5 to do one question in closing for you,
6 Commissioner.
7 So my last two colleagues asked you
8 about the program in the local jails, mental
9 illness. In the General Welfare/ Human
10 Services hearing we had last week, one of the
11 discussions was that approximately 3200
12 people are released from the prisons directly
13 into the entry point for the New York City
14 Men's Shelter. A disproportionately large
15 number of them suffer from mental illness.
16 That surely can't be a smart discharge plan
17 for someone with mental illness: Okay, we're
18 letting you out of jail, and welcome to the
19 streets of New York.
20 I'm going to ask this in the Public
21 Protection hearing of DOCCS, but can you
22 please tell me what the right answer should
23 be? Because I know that this can't be the
24 right answer.

1 COMMISSIONER SULLIVAN: Well, we know
2 that basically if individuals with serious
3 mental illness leave prison, that they do
4 best when they are in housing which is
5 supported by a series of services that
6 enhance their ability to reenter into the
7 community.
8 We do a lot of work in the prisons
9 before they are discharged to help the
10 seriously mentally ill get ready to go into
11 the community. And just last year -- and
12 we're in the process of putting forward these
13 units, 250 additional apartment units were
14 authorized for individuals leaving the prison
15 system at the highest need, to be able to
16 move to housing which would be run by the
17 particular agencies that do very good work
18 with the forensic population.
19 We try as best as we can for most of
20 the seriously mentally ill leaving to get
21 into some degree of housing, whether it's
22 apartments or other kinds of family housing,
23 whatever is possible. Some of the seriously
24 mentally ill do unfortunately end up going to

1 the shelters, sometimes for -- hopefully, as
2 often as possible -- for a briefer period of
3 time waiting to get into the other housing.
4 But we do the best we can to try not to have
5 them go to shelters, because you're right,
6 it's not the best disposition.
7 CHAIRWOMAN KRUEGER: But you are
8 working with or IDing people in prison as
9 suffering from mental illness.
10 COMMISSIONER SULLIVAN: Oh, yes.
11 Before discharge we know all the individuals
12 who are seriously mentally ill. We also know
13 their risk levels. So we prioritize for the
14 high-risk clients to be able to go out into
15 housing. Some of the lower-risk clients,
16 unfortunately sometimes we don't have enough
17 housing so they go to the shelters.
18 But every client who leaves is
19 assessed for their ability to go. And if
20 they are assessed before they leave prison to
21 need additional help before going, they go to
22 one of the pre-discharge units in the prison
23 system. We have two of those, and we're
24 going to be expanding to another one, where

1 they spend anywhere from several months
2 getting ready to leave the prison system to
3 reintegrate into the community.
4 CHAIRWOMAN KRUEGER: And at that time
5 you're attempting to find them someplace
6 where they would move to as opposed to the
7 shelters or the streets.
8 COMMISSIONER SULLIVAN: Yes. Yup,
9 absolutely. Yes.
10 CHAIRWOMAN KRUEGER: And is there some
11 kind of data report you can get for me and my
12 colleagues --
13 COMMISSIONER SULLIVAN: Yes.
14 CHAIRWOMAN KRUEGER: -- showing --
15 that would be very helpful.
16 COMMISSIONER SULLIVAN: I can show you
17 -- we have the numbers and we have where the
18 individuals go, how many go into them. We
19 can definitely get that to you. Be glad to.
20 CHAIRWOMAN KRUEGER: Thank you very
21 much for your time with us this morning. You
22 are now free.
23 (Laughter.)
24 CHAIRWOMAN KRUEGER: Well, you might

1 not be free, but you're allowed to leave this
2 room. Let's not go too far. Sorry.
3 Our next witness is the commissioner
4 of the Office for People With Developmental
5 Disabilities, Dr. Theodore Kastner.
6 Good afternoon.
7 COMMISSIONER KASTNER: Good afternoon,
8 Senator.
9 Good morning, Chairs Krueger,
10 Weinstein, Carlucci and Gunther and other
11 distinguished members of the Legislature. My
12 name is Ted Kastner, commissioner of the New
13 York State Office for People With
14 Developmental Disabilities, or OPWDD.
15 Thank you for the opportunity to
16 provide testimony about Governor Cuomo's
17 fiscal year '20-'21 Executive Budget and how
18 it will benefit the more than 140,000 New
19 Yorkers with developmental disabilities
20 served by OPWDD.
21 It has been just over a year since I
22 assumed leadership of OPWDD, and I'd like to
23 begin my testimony by highlighting some
24 accomplishments of the past year. In regard

1 to our work with our partners, in 2019 we
2 received federal approval to provide crisis
3 services for individuals with intellectual
4 and developmental disabilities, or CSIDD.
5 This Medicaid State Plan amendment allows us
6 to double our service capacity with the same
7 investment of state dollars. We will use
8 these funds to complete our statewide network
9 of crisis response services.
10 We're collaborating with the Office of
11 Mental Health to create new programs to
12 support individuals with severe, challenging
13 behaviors. These include a new inpatient
14 unit in Brooklyn and a new extended treatment
15 unit in Queens. We're exploring avenues to
16 enhance the skills of primary care and
17 behavioral health providers.
18 Complementing these efforts, we're
19 working diligently to improve collaboration
20 with our partners in county government. We
21 have regular meetings with the counties and
22 are exploring opportunities to coordinate
23 state and county resources to improve crisis
24 response outcomes.

1 We've achieved our goal of ensuring
2 that all OPWDD-eligible individuals have a
3 life plan developed by our care coordination
4 organizations, or CCOs. We're now working to
5 ensure that these life plans meet the
6 standards of being conflict-free and
7 person-centered.
8 In August of 2018, OPWDD published the
9 draft Specialized IDD Plans-Provider Led, or
10 SIPs-PL, qualification document for public
11 comment. We anticipate releasing a revised
12 draft for public comment soon.
13 Internal activities in 2019 have
14 helped lay a foundation for a more effective
15 system of support in the future. We have
16 restructured our leadership team and are
17 working to improve public engagement through
18 our advisory committees. OPWDD conducted a
19 thorough review of the organizational
20 structure and functions of approximately
21 20,000 employees to ensure that resources are
22 deployed to best meet the needs of people we
23 support.
24 We created a new Division of Data

1 Management and Strategy to enable
2 better-informed decision-making and to
3 promote data transparency. This will support
4 IT development and data analytics.
5 We're midway through the
6 implementation of an electronic health
7 records system for all state-operated
8 services. We've secured a five-year renewal
9 of our federal Medicaid waiver, allowing us
10 to support more than 90,000 people in their
11 own home or community.
12 And finally, OPWDD strengthened
13 central office oversight of policy, budgeting
14 and program operations and has now begun to
15 reorganize the regional office structure to
16 streamline operations.
17 As a result of all these improvements,
18 all individuals and families have the same
19 access to supports and services no matter
20 where they live, what language they speak,
21 their race, religion or when they became New
22 Yorkers.
23 The Governor's Executive Budget
24 continues to build upon these successes,

1 including significant new investments now
2 leveraging approximately $9 billion in state
3 and federal funding for OPWDD services and
4 programs. These include $120 million in
5 annual all-shares funding to provide new and
6 expanded services for people entering the
7 OPWDD system for the first time; $15 million
8 in capital funding to expand housing
9 opportunities; and $170 million in new state
10 and federal resources to comply with the
11 state's minimum wage, to increase wages for
12 direct support professionals, and to support
13 our clinical staff employed by OPWDD's
14 network of nonprofit providers.
15 These additional human capital
16 investments bring the total commitment to
17 increased wages and compensation to our
18 nonprofit provider workforce to $650 million
19 since 2015.
20 New York leads the nation in the
21 amount of funding to support people with
22 developmental disabilities, providing twice
23 the national per-capita average. As we move
24 into 2020 and beyond, OPWDD will continue to

1 transform the delivery system to one that is
2 more accessible, equitable and sustainable.
3 New York's evolution to be a more responsive
4 and flexible service system would not be
5 possible without our collaborations with the
6 Legislature, the input of the people we
7 support and their family members, and our
8 dedicated partners in the provider community.
9 Thank you for your partnership, and I
10 look forward to answer any questions you may
11 have.
12 CHAIRWOMAN KRUEGER: Thank you.
13 Our first questioner will be Chair
14 David Carlucci.
15 SENATOR CARLUCCI: Thank you, Chair.
16 Thank you, Commissioner, for your
17 testimony today, and for your commitment to
18 our most vulnerable populations. And I know
19 we've spoken at length about the need to
20 support our workforce. It's the backbone of
21 the developmental disability system. And
22 it's a struggle that we still have. Every
23 day I hear about the concerns and the
24 complaints about the transition of the

1 workforce. And you can't blame them when
2 they're paid minimum wage or just above, in
3 some cases, to do the hardest work. And that
4 transition is just -- it really eats at the
5 quality of care.
6 So my hat goes off to the
7 professionals, the people that -- the DSPs
8 that have been there, that have done it as a
9 career. They pull together because of their
10 love and commitment to the people they serve,
11 so I thank them for that.
12 I first wanted to get into -- because
13 we'll get into the workforce, but the big
14 pressing issue is about the transition to
15 managed care. And we've heard about this,
16 but yet it's something -- little details have
17 been provided, at least that I'm aware of.
18 Is New York still moving to -- are we still
19 transitioning to managed care? And if so,
20 what is the time frame?
21 COMMISSIONER KASTNER: Thank you,
22 Senator. We have a process for the
23 transition to managed care. At the present
24 time there are two primary components to

1 that. The first was in July of 2018, we
2 launched our care coordination organizations.
3 The effort was designed to expand the scope
4 of our case management program and to
5 incorporate healthcare services in addition
6 to habilitative services, into what we now
7 call a life plan. So our care management
8 system is now building the competency to be
9 able to incorporate both health and
10 long-term-care services.
11 In August of 2018, we published the
12 draft SIPs-PL qualifications document. We
13 received about 80 public comments on how that
14 document could be enhanced. We've been
15 working on revisions to that document while
16 we're simultaneously working to ensure that
17 our CCO launch has been effective. We are
18 near the end of completing a revision to that
19 draft SIPs-PL qualification document, and we
20 expect that draft to be made available to the
21 public soon.
22 SENATOR CARLUCCI: What do you think,
23 how soon?
24 COMMISSIONER KASTNER: I think soon.

1 (Laughter.)
2 COMMISSIONER KASTNER: I have to say
3 I --
4 SENATOR CARLUCCI: Because we've kind
5 of heard that before.
6 COMMISSIONER KASTNER: I've said this
7 before. Actually, I went on record in saying
8 in September it would be out in October or
9 November, in November it would be out in
10 December, and obviously I've been wrong on
11 both counts.
12 So I'm a little uncomfortable saying
13 that it will be a specific date, although we
14 do expect it to be out shortly.
15 SENATOR CARLUCCI: Okay. And one of
16 the big concerns that we have is obviously
17 that -- the difference between state-operated
18 and voluntary services. Do you have an idea
19 or a breakdown of what percentage of the
20 covered population is covered under
21 state-operated work and the nonprofit work?
22 Do you have any idea what the breakdown is?
23 COMMISSIONER KASTNER: Yeah, a rough
24 ballpark is approximately 20 percent of the

1 service delivery system is provided through
2 OPWDD state employees and 80 percent through
3 the voluntaries. For residential, it's
4 pretty easy to look at: About 30,000
5 certified residential opportunities through
6 the voluntaries, about 7,000 certified
7 residential opportunities through OPWDD.
8 SENATOR CARLUCCI: One of the concerns
9 that we keep hearing about the transition to
10 managed care is that there would be start-up
11 costs that possibly have to be put out. Can
12 you tell us, is that -- would that be true?
13 Can we give a guarantee? Can we put people
14 at ease to say that no money from services
15 would be taken out in order to meet those
16 start-up costs?
17 COMMISSIONER KASTNER: We have said
18 that in the past. We do not have start-up
19 costs in our operating budget, and we believe
20 that that is still the case. The operating
21 costs for administration and start-up would
22 come from another source.
23 SENATOR CARLUCCI: Okay. And does
24 there seem -- when we talk about we have the

1 80 percent that's run outside of the OPWDD
2 state-run system, does OPWDD track the fiscal
3 health of the nonprofit providers?
4 COMMISSIONER KASTNER: Yes, we do.
5 Our providers are compensated through a
6 cost-based reimbursement mechanism. So for a
7 base year they submit to us the list of the
8 costs that they incur in providing services
9 to our individuals. We incorporate that
10 information into the rates that are paid to
11 them. It's probably the most favorable
12 reimbursement methodology that could be used
13 to provide payment to providers, because it's
14 based on their historical costs.
15 SENATOR CARLUCCI: I'm sorry, what was
16 that last part you said?
17 COMMISSIONER KASTNER: It's a very
18 favorable reimbursement methodology. As
19 opposed to a fee or a capitation arrangement,
20 payment based on costs actually makes
21 providers whole as a result of, you know,
22 being fully compensated for the services
23 they're providing.
24 SENATOR CARLUCCI: Okay. And we have

1 been pushing, we've got the
2 BFair2toDirectCare campaign. We were
3 successful in putting some money into the
4 budget last year. I had asked the
5 commissioner of OMH the same question about
6 we're hearing about that the 2 percent
7 increase has not been put out the door yet,
8 and that's putting many of the providers at a
9 very challenging cash-flow situation.
10 Can you explain to us what's going on
11 with that? Is money getting out the door to
12 the providers? Is there a holdup? Am I
13 mistaken, has that money gone out? Where are
14 we?
15 COMMISSIONER KASTNER: We are very
16 grateful for the Legislature, in the
17 Executive Budget of last year, incorporating
18 a 2 percent increase for direct support
19 professionals on January 1st and also
20 April 1st for this coming budget.
21 My understanding is that OPWDD has
22 approved the new rate that would incorporate
23 the increase for DSPs, but we're waiting to
24 see that that is processed and then delivered

1 to the providers.
2 I don't know specifically where the
3 holdup is, but I do know that we have
4 approved those rates for providers for the
5 January 1st increase.
6 SENATOR CARLUCCI: So but is it your
7 understanding that that money has not been
8 sent out the door yet?
9 COMMISSIONER KASTNER: From what the
10 providers have told me, it has not yet
11 arrived.
12 SENATOR CARLUCCI: Okay. So we need
13 to --
14 COMMISSIONER KASTNER: We can look at
15 where that is. It's somewhere between,
16 obviously, OPWDD and our providers.
17 SENATOR CARLUCCI: Okay. Okay.
18 We've talked about it before, about
19 what do we do to increase the longevity of
20 our employees. And I've talked to you about
21 the idea of a credentialing program, that we
22 pay people for their experience.
23 Is there anything in the works through
24 OPWDD to have a program where we are actually

1 paying people for their experience to make
2 sure that that longevity continues? We have
3 agreed in meetings that that longevity is
4 paramount to the quality of care. It drives
5 down the cases of neglect, of abuse, and just
6 improves the continuum of care.
7 Can you tell us, is there anything in
8 the budget that you can point to here, plans
9 that OPWDD has to strengthen the workforce
10 and to make sure that there's more of an
11 incentive, that this is an actual career, a
12 long-term career for people?
13 COMMISSIONER KASTNER: Well, Senator,
14 as you know, when we met I told you that my
15 first job in this field was in 1976 as a DSP.
16 SENATOR CARLUCCI: Yes.
17 COMMISSIONER KASTNER: So I understand
18 the challenge of the work and the importance
19 of the work. DSPs are the line staff, the
20 individuals who have the most day-to-day
21 contact with our individuals. So we value
22 the DSPs. We have to find ways to create
23 stability in that workforce and opportunities
24 for professional development.

1 As far as salary, the last I was able
2 to determine, looking at data from probably
3 2015, the average salary for DSPs in New York
4 was about $13.65, which put us in the top
5 five nationally. I think with the subsequent
6 increases that have occurred, we're near $15
7 an hour, we're near the very top in terms of
8 the rest of the country. And certainly we're
9 favorably positioned relative to the states
10 that we compete against -- Pennsylvania,
11 New Jersey, New Jersey, Connecticut,
12 Massachusetts, Vermont. We're certainly not
13 losing workforce to those states.
14 We have tried to identify
15 opportunities to leverage resources. We
16 can -- we're conducting public service
17 announcements in the North Country
18 specifically reaching out to veterans at the
19 time of separation from service, identifying
20 a DSP role as a potential career path. We've
21 been able to identify benefits that are
22 available from the Department of Veterans
23 Affairs that enhance salary and compensation.
24 We've also identified that veterans are --

1 can benefit from enhanced entitlements like
2 the SNAP Plus program.
3 We are working with academic
4 institutions. We have two different groups
5 working with the BOCES programs, one in
6 Nassau and Suffolk Counties and the other
7 upstate, to develop a curriculum and a
8 certificate. I went to the graduation for
9 DSPs on Long Island, it must have been in the
10 fall, because that's an extremely important
11 area for us.
12 We're also looking at credentialing,
13 any number of activities that we can to
14 elevate the quality of the work and the
15 prestige associated with the role. It turns
16 out it's not simply an issue of economics. I
17 think people in the role value recognition
18 and the credit for the work that they do. So
19 working within both the state operations and
20 our voluntaries to have a DSP Recognition
21 Week and recognition events has been very
22 important.
23 I've been to every part of this state
24 celebrating DSPs and attending the

1 recognition events, which again we think is
2 very important for setting a tone in how we
3 value DSPs.
4 SENATOR CARLUCCI: Thank you.
5 CHAIRWOMAN KRUEGER: Thank you.
6 Assembly.
7 CHAIRWOMAN WEINSTEIN: We've been
8 joined by Assemblywoman Kimberly Jean-Pierre
9 and Assemblywoman Rosenthal, and go to
10 Assemblywoman Gunther, chair of our Mental
11 Health Committee, for questions.
12 ASSEMBLYWOMAN GUNTHER: Good morning.
13 So I'm not going to ask you about the DSPs.
14 We all know that we're looking for more money
15 for retention for our DSPs, it's a group of
16 women. So I know that you're working on
17 that, and we're happy about that.
18 Thirteen dollars -- you know,
19 McDonald's in the city just raised to $15.
20 So, you know, there's a little competition
21 here. And this is people's lives. So -- but
22 I know that you're working on it, and I do
23 appreciate it.
24 So my next issue is bed blockers --

1 that is, children who have aged out and
2 should be in adult beds but continue to be an
3 issue, they stay in children's beds. And you
4 know that we have a place that I represent in
5 Sullivan County that we have quite a few bed
6 blockers, and there really is not very many
7 places to move these folks to, and it is an
8 issue.
9 So are we doing anything to create
10 more adult beds in the DD community?
11 COMMISSIONER KASTNER: Well, as you
12 will recall, in 2017 we received the support
13 to build 459 new certified residential
14 opportunities. We're about midway through
15 that process in building new residential
16 capacity. We also have $15 million in
17 affordable housing capital available in this
18 year's budget which will help us address that
19 concern. And we also have the capacity to
20 offer between 1200 and 1300 new residential
21 opportunities each year.
22 So we recognize that is a problem.
23 We're looking at how we can address that both
24 in terms of the individuals who occupy those

1 beds, but also in making strategic
2 investments in a continuum of care in order
3 to reduce the pressure on those programs in
4 terms of the numbers of children that are
5 requesting residential services.
6 I'm sure I'll have an opportunity to
7 touch on that in a bit.
8 ASSEMBLYWOMAN GUNTHER: Thank you.
9 Now, managed care and the CCO issue is next.
10 How can the Executive believe that moving to
11 managed care will save the system money.
12 It's just going to be another mouth to feed.
13 When you theoretically take the same pot of
14 money and add it to an entire another
15 administration apparatus, what other
16 conclusion can I and everybody else come to?
17 COMMISSIONER KASTNER: Well, as I
18 think everyone within OPWDD has said, the
19 move to managed care is not for the purposes
20 of saving money. And as I described it
21 earlier, we have a process in place where we
22 don't have specific timing. The process
23 begins --
24 ASSEMBLYWOMAN GUNTHER: Can you pull

1 the mic a little closer? Because I can't
2 really hear you as clear as I should.
3 COMMISSIONER KASTNER: Sure. I have a
4 problem with mumbling, and I have an FM radio
5 voice --
6 ASSEMBLYWOMAN GUNTHER: So do I.
7 COMMISSIONER KASTNER: -- so I can put
8 anybody to sleep.
9 (Laughter.)
10 COMMISSIONER KASTNER: But, you know,
11 we're making investments to address the
12 transition to managed care. The process
13 right now is focusing on the CCOs and
14 ensuring that all of our individuals have an
15 appropriate care plan and also the policy
16 framework being the SIPs-PL qualifications
17 document, which is currently under revision.
18 Those are the two steps that we're currently
19 engaged in. We don't have time frames
20 specifically for going forward.
21 ASSEMBLYWOMAN GUNTHER: Do you think
22 managed care works in the DD system or will
23 work in the DD system, it will save money or
24 create better care? We should be -- the

1 focus should be on the quality of care, but
2 it's all soft core so a lot of it has to do
3 with money rather than quality.
4 And, you know, so far I don't think
5 that there are many people that are bragging
6 about managed care.
7 COMMISSIONER KASTNER: Well, as I said
8 before, the focus on implementing managed
9 care for people with developmental
10 disabilities is not focused on saving money.
11 One of the facts I think that's not
12 readily appreciated is that more than 28,000
13 people with intellectual and developmental
14 disabilities have volunteered to enroll in
15 mainstream managed care, and we believe
16 that's largely because it provides better
17 access to healthcare services for individuals
18 -- services that in the fee-for-service
19 Medicaid program might not be as accessible.
20 Generally that experience has been
21 favorable. Individuals enroll on a voluntary
22 basis; they can also disenroll on a voluntary
23 basis. So we think managed care as a safety
24 net for Medicaid State Plan services has been

1 very helpful.
2 As I said in regard to provider-led
3 plans, we're still in the process of
4 preparing the revised draft for public
5 comment. We hope that that will be out
6 shortly, and that will give us more insight
7 into the feelings of our individuals and
8 families as to whether or not we should
9 pursue it and the timing and scope as we go
10 forward.
11 ASSEMBLYWOMAN GUNTHER: So will
12 services have to be cut for managed care and,
13 you know, the uniqueness of the service that
14 -- the services that you provide to those
15 individuals?
16 You know, when I think about managed
17 care, like, you know, you take in their age,
18 there are different factors you take in. But
19 in the DD community it seems like there's so
20 many different things that could cost
21 additional money because of the child or the
22 adult themselves.
23 So managed care is we did it to save
24 money. And I'm just wondering, you know,

1 what else will be cut. Right now we know
2 that we're not paying DSPs, to me, enough
3 money because we can see the turnover. And
4 now we're on managed care, you know. And the
5 hospital systems, I don't know that they got
6 their big bang for the buck that they thought
7 they were going to get, nor did they get the
8 streamlined care that no infection or nothing
9 unheard-of would happen, or something
10 unexpected.
11 And I just sometimes wonder, with this
12 unique community, how that's going to fit
13 into it.
14 COMMISSIONER KASTNER: So the value
15 proposition, if you will, in managed care is
16 that managed-care organizations can avoid the
17 need for unnecessary services. So by keeping
18 people healthy, for example, they can reduce
19 the amount of emergency room care or hospital
20 care. And that premise is generally proven,
21 I think, for all people who are Medicaid
22 beneficiaries in virtually every state at
23 this point.
24 ASSEMBLYWOMAN GUNTHER: I like the

1 fact that, you know, we do that in acute-care
2 hospitals. And so on one side we're saying,
3 yeah, better care, but on the other side
4 we're saying we've got this turnover of DSPs.
5 So one has to be worked out with the other in
6 order to have any efficacy of these kind of
7 changes.
8 And you know what, the investment over
9 the years is getting better, but the
10 investment in our most vulnerable
11 populations, whether it's Mental Health or
12 OPWDD -- you and I have been in those
13 facilities, we've seen the people that work
14 there, that are working at one facility on
15 one end of the town and the other facility.
16 So I think that these ideas that, you
17 know, that are thrown out -- thrown at us
18 every X amount of years, they sound great.
19 But, you know, have we seen a great deal of
20 change in the acute-care facilities? A lot
21 of readmissions, sometimes, but other than
22 that I'm not really sure that it's been as
23 effective as we think.
24 That's my last question.

1 COMMISSIONER KASTNER: Thank you.
2 ASSEMBLYWOMAN GUNTHER: I don't know
3 if you have a comment on it.
4 COMMISSIONER KASTNER: Thanks.
5 CHAIRWOMAN KRUEGER: Okay. Senator
6 Pete Harckham.
7 SENATOR HARCKHAM: Thank you, Madam
8 Chair.
9 Thank you, Commissioner. Thank you
10 and your staff for all you do. I want to
11 thank the treatment providers and the family
12 caregivers. You know, this population that
13 doesn't have high-priced lobbyists, you know,
14 doesn't have star-studded, you know,
15 walkathons -- and so the people who are
16 committed to this, you know, you're doing
17 God's work and you deserve to be commended.
18 The question I have -- going back to
19 your testimony, you talk about 15 million
20 capital for housing. Many of us in our
21 districts have existing housing, group homes
22 or whatever, through various agencies that
23 have been there a while. And what they need
24 is new capital. They need reinvestment. You

1 know, they're at a point where they need new
2 roofs, maybe new boilers, maybe new siding,
3 whatever it is. And that's expensive.
4 Is reinvestment in existing properties
5 part of this capital expenditure? Or is
6 there money for that in other parts of your
7 budget?
8 COMMISSIONER KASTNER: The
9 reinvestment in capital for existing
10 residential capacity is within the providers'
11 budgets. These funds are for the expansion
12 of new affordable housing.
13 SENATOR HARCKHAM: All right, so
14 there -- you're -- I'm sorry, I didn't hear
15 you. So you're saying that you're assuming
16 there's capacity in providers' existing
17 budgets to do capital?
18 COMMISSIONER KASTNER: I'd have to
19 look specifically at how that is funded, but
20 I believe that that is not within the scope
21 of the $15 million that's within this year's
22 budget.
23 SENATOR HARCKHAM: Okay. Is there any
24 other funding, to your knowledge, anywhere in

1 your budget that will assist with capital for
2 existing facilities to repair
3 infrastructure -- new roofs, new boilers,
4 those kind of things?
5 COMMISSIONER KASTNER: Yeah, I need to
6 go back and ask our budget people that
7 question. I apologize, I don't have the
8 specific answer.
9 SENATOR HARCKHAM: Okay. No, that's
10 fine. We can touch base afterwards.
11 COMMISSIONER KASTNER: Okay.
12 SENATOR HARCKHAM: All right, thank
13 you.
14 COMMISSIONER KASTNER: Thank you.
15 (Pause.)
16 CHAIRWOMAN KRUEGER: Sorry. I'm so
17 sorry. Thank you.
18 Next is Assemblymember Miller.
19 ASSEMBLYWOMAN MILLER: Hello.
20 COMMISSIONER KASTNER: Hi.
21 ASSEMBLYWOMAN MILLER: So as I'm sure
22 you're familiar, I have way more questions
23 than we are given time for. So I will focus
24 on the issues, as usual, that I'm hearing

1 most concern about from the families that
2 reach out to me from all over the state.
3 The first has already been spoken
4 about a little bit: Our transition into full
5 managed care. I know you've heard this
6 before, even from me, but this model has not
7 been successful in other states in this
8 population. Why are we so insistent that it
9 will be here?
10 I can tell you that currently there is
11 little confidence on the part of the
12 consumers who are stuck in this constant
13 transition. Families and agencies were sold
14 an amazing program -- care coordinators with
15 graduate degrees who understood the needs of
16 this community; they would be able to take so
17 much off of our shoulders. We're certainly
18 not seeing that. There is a tremendous
19 turnover rate, much more so than before, I
20 feel.
21 I myself, with Oliver, we're on our
22 third care coordinator in a year. They're
23 inexperienced in the actual coordinating
24 that's required for this good care that we

1 were told was going to follow this. Many of
2 them have been taken out of classrooms
3 because at least they've dealt with this
4 population, but unfortunately it doesn't mean
5 that they know how to do what's required.
6 This is not what we were told would be
7 happening.
8 As I often say, you don't know what
9 you don't know. And if the care coordinators
10 don't know and the family doesn't know, guess
11 what? The individual is not getting what
12 they should be.
13 I'm sure you've heard all about the
14 CDPAP program and that it's been a target,
15 and now it's being looked at as one of the
16 reasons that the Medicaid deficit is so
17 great. And I realize that has nothing to do
18 with OPWDD. But the bottom line, from your
19 perspective, is that if these drastic
20 cuts are made to CDPAP, there will be a much
21 greater need for OPWDD services like
22 residential placement in group homes, since
23 these individuals will not be able to stay in
24 their home care environments.

1 Currently it's allowing people to keep
2 their loved ones at home. We know there
3 aren't enough slots for residential placement
4 right now, and I've heard you testify that
5 you're increasing that. But what -- we
6 really need to address this need for more
7 housing, whether it be group home, supportive
8 living, et cetera. This is coming.
9 There's also a rumor of cuts to the
10 comm-hab staffing. This combination of CDPAP
11 and comm-hab are what enable individuals to
12 live successfully in supportive living or
13 apartments. Removing these supports will be
14 devastating -- and then what do you do with
15 us? This is the most frequent question that
16 I get from families: What are we going to
17 do?
18 COMMISSIONER KASTNER: Well, as I
19 described our planning for managed care, we
20 have to be assured that the care coordination
21 organizations are effective at delivering
22 person-centered, conflict-free case
23 management.
24 The CCOs launched July 1st of 2018.

1 When I arrived in January of last year, I
2 believe it's fair to say they were well
3 behind in their development of life plans for
4 individuals. We specifically focused on that
5 issue over the next year. I am pleased that
6 as of the end of January, all individuals
7 served through CCOs do have a life plan.
8 That only means they have a life plan.
9 It doesn't mean that it is an adequate life
10 plan, that it is person-centered or
11 conflict-free.
12 ASSEMBLYWOMAN MILLER: Or that they
13 have the services that they needed.
14 COMMISSIONER KASTNER: I certainly can
15 give that to you.
16 But I will say that since July, when
17 it became apparent that we would then be
18 on-target for each individual having a life
19 plan, we began weekly meetings with CCOs to
20 focus on the more qualitative aspects of the
21 plan -- you know, were they person-centered,
22 did they provide services? We began looking
23 at things like agency turnover and agency
24 staffing.

1 We've had weekly meetings with CCOs.
2 We're in the process of developing a
3 performance report card based on metrics.
4 We've told the CCOs that we plan to put
5 information on our website to make it
6 available for the public to see what percent
7 of individuals who are enrolled have life
8 plans and to look at their performance
9 relative to each other --
10 ASSEMBLYWOMAN MILLER: Are you asking
11 the families or the individuals or just the
12 CCOs? Having a life plan is having a life
13 plan. But are you asking the families are
14 they getting what they need?
15 COMMISSIONER KASTNER: We're not
16 serving the families specifically, we're
17 talking with the CCOs at this point.
18 There is an opportunity to pull data
19 off the life plans because they're now
20 aggregated in an IT platform. But we
21 certainly are open to looking at metrics that
22 families may recommend as being important to
23 them.
24 It's a process of evolution. But I

1 want to tell you, it's already underway and
2 we plan on making that information available
3 to people so that they can make an informed
4 decision about the quality of care --
5 ASSEMBLYWOMAN MILLER: I think as
6 usual the families are the last to be
7 contacted, to be reached out to to see how is
8 this working.
9 COMMISSIONER KASTNER: But we have
10 revitalized, I think, the input from
11 consumers both through our mandatory advisory
12 committees and through other committees. We
13 have numerous meetings with different parent
14 advisory groups from around the state and
15 also much more locally. We've really strived
16 to improve our ability to work with families
17 and communicate with them.
18 CHAIRWOMAN WEINSTEIN: Thank you.
19 We go to the Senate now.
20 CHAIRWOMAN KRUEGER: Senator Jim
21 Seward.
22 SENATOR SEWARD: Thank you,
23 Madam Chair.
24 And Dr. Kastner, thank you for being

1 here this morning -- or afternoon, I should
2 say.
3 I wanted to continue the discussion a
4 bit longer on the CCOs. And I just wanted to
5 ask you directly, are there concerns that
6 you're hearing from providers, families or
7 other interested parties that are being
8 brought to your attention through the -- you
9 mentioned advisory groups and so on. But are
10 you hearing concerns that you could share
11 with us?
12 And also I would note that in last
13 year's budget for fiscal year 2020, the
14 enacted budget included $5 million to help
15 providers with the transition to managed
16 care. I note that that sum of money is not
17 included in this year's Executive proposal.
18 Is it no longer needed? Or is this something
19 that should be continued? Why weren't these
20 additional funds included in this year's
21 Executive Budget?
22 COMMISSIONER KASTNER: To the second
23 question, there was last year an
24 appropriation of $5 million for provider

1 organizations to provide technical assistance
2 to our community providers for the purposes
3 of managed-care readiness. They've created a
4 managed-care community of practice, are
5 working with provider agencies on the
6 potential transition to managed care.
7 I don't believe that there are funds
8 in this year's budget. I can go back and
9 look.
10 And if you can just repeat the first
11 part of the question, I'd be happy to address
12 that again.
13 SENATOR SEWARD: Well, I was just
14 curious to hear whether or not you are
15 getting any concerns from providers,
16 families, and other interested parties in
17 terms of how this rollout of the CCOs, how
18 that's working. Do you have concerns
19 directed to you?
20 COMMISSIONER KASTNER: Absolutely.
21 The CCO rollout was one of the most
22 important issues that was presented to me in
23 early February when I arrived. At that point
24 the number of individuals receiving life

1 plans was far below what we expected, and we
2 pushed the providers to meet time targets
3 over the course of this year. So at this
4 point every individual has a life plan.
5 Again, we're focusing on the quality
6 of those life plans because we're still
7 continuing to hear concerns from families and
8 individuals as to whether or not those life
9 plans are adequate.
10 SENATOR SEWARD: And how are you
11 reacting to those concerns?
12 COMMISSIONER KASTNER: Well, as I
13 said, there are carrots and sticks that we
14 can use. And we meet with the providers and
15 provide them technical assistance, looking at
16 their benchmarks. But we've also told them
17 we think this is important information to
18 share with the public. Once we redesign our
19 website, we will be creating a place on the
20 website for people to look at CCO performance
21 and judge for themselves how well they're
22 doing. We think that that type of public
23 disclosure is really to the benefit of our
24 individuals and families and should drive

1 performance.
2 SENATOR SEWARD: Okay, thank you.
3 Just one final question. I wanted to
4 shift gears to the issue of can you share
5 with us some of the latest developments on
6 the sheltered workshop transitions to
7 integrated work settings as well as
8 intermediate care facilities' conversions and
9 the other Home and Community Based
10 Waiver-related compliance actions?
11 Specifically on the -- transitioning
12 our sheltered workshops, one concern that I
13 have when I tour the workshops in my
14 district, many of these folks would like to
15 continue to be working there. That's what
16 they know, that's what they want. And is
17 this going to continue to be possible? If
18 you could just give us an update on how
19 that's going.
20 COMMISSIONER KASTNER: Sure. As you
21 know, we are transitioning from sheltered
22 workshops to employment, competitive
23 employment and supported employment. As of
24 last year, I believe, there were about

1 30 agencies that were operating sheltered
2 workshops. More than half of them had
3 successfully completed a transition to some
4 form of employment or supported employment.
5 I don't have more specific data than that,
6 but I can obtain that. I can provide it to
7 you at a later time, if that would be okay.
8 SENATOR SEWARD: Thank you.
9 CHAIRWOMAN WEINSTEIN: We go now to
10 Assemblywoman Rosenthal.
11 ASSEMBLYWOMAN ROSENTHAL: Thank you.
12 OPWDD transitioned from about 350
13 Medicaid service coordinating organizations
14 to seven care coordination organizations to
15 try to eliminate conflicts in the case
16 management system. Do you know if providers
17 are able to open their own CCOs and recommend
18 the individual receive services through that
19 provider?
20 COMMISSIONER KASTNER: You are correct
21 that one of the goals of the CCO
22 implementation was to create a system that
23 was conflict-free. We collaborated with the
24 Department of Health to implement CCOs using

1 the health home model. The Department of
2 Health is the primary regulator of CCOs.
3 We also coordinated with CMS about the
4 design of CCOs and the role of providers in
5 helping to create CCOs. We believe that that
6 satisfied CMS in terms of the requirement to
7 be conflict-free.
8 ASSEMBLYWOMAN ROSENTHAL: I mean it's
9 just about a year old, right, or less than a
10 year old?
11 COMMISSIONER KASTNER: I'm sorry, I
12 didn't hear the question.
13 ASSEMBLYWOMAN ROSENTHAL: This has
14 just been in place for a short time. But
15 have you heard back from individuals or their
16 families in terms of how satisfied they are
17 with the services?
18 COMMISSIONER KASTNER: I believe that
19 generally satisfaction is one of the metrics
20 that we're looking at. I don't have that
21 data offhand. But we are talking with
22 families and individuals about their
23 satisfaction. And obviously there are
24 opportunities for improvement in that regard.

1 ASSEMBLYWOMAN ROSENTHAL: Do you
2 believe a managed care company paying a
3 capitated rate will lead to higher-needs
4 individuals receiving less care?
5 COMMISSIONER KASTNER: Well, as I
6 described it, we have a process for the
7 implementation of managed care. We're at the
8 beginning of that process. We're just now
9 revising the draft SIP-PL document.
10 Managed care implementation will
11 depend upon, I think, the feedback that we
12 get on that document. There are many ways in
13 which managed-care implementation could
14 occur. It could be focused on state plan
15 services versus waiver services, it could be
16 focused on certain types of beneficiaries --
17 for example, people with Medicaid, people who
18 are dually eligible through Medicaid and
19 Medicare, people with medical insurance. It
20 could be phased in in different geographies.
21 There are many inputs to an answer
22 that we're really not prepared to offer at
23 this point.
24 ASSEMBLYWOMAN ROSENTHAL: And when do

1 you think you will be?
2 COMMISSIONER KASTNER: Well, again,
3 the process is to publish the revised draft
4 SIP-PL qualifications document, ask for the
5 public input, and see what they think of the
6 revisions that we will be making.
7 ASSEMBLYWOMAN ROSENTHAL: Okay, thank
8 you.
9 CHAIRWOMAN WEINSTEIN: We go to
10 Senator Savino for questions.
11 SENATOR SAVINO: Thank you,
12 Assemblywoman.
13 Commissioner, this question may have
14 been asked previously when I was out of the
15 room, I apologize. But I did say that I
16 would ask on behalf of the affected
17 individuals. I do want to, though, echo the
18 comments of many of my colleagues with
19 respect to housing issues. This week it's --
20 I think we're going to be having the
21 Developmental Disabilities Breakfast in
22 Staten Island, and there will be another one
23 in Brooklyn, and it is the number-one issue
24 that comes up over and over as aging parents

1 are more and more concerned about what will
2 happen to their sons and daughters if they're
3 not around. So we've got to solve this
4 housing crisis.
5 Again, I believe it's the shame of
6 this state the way we treat human service
7 workers, particularly direct support
8 professionals. That they're equated with
9 minimum wage work, it's just -- it's
10 outrageous. But it is what it is.
11 Last year, in an effort to satisfy the
12 #bFair2DirectCare campaign, where the
13 Governor proposed -- and it was adopted --
14 another deferral of the COLA, the human
15 service COLA, we did commit to an additional
16 2 percent to the agencies. I'm being told by
17 several of the agencies in my district that
18 they're not collecting that money yet. In
19 fact, they won't -- they anticipate they
20 won't get it till after this budget is put to
21 bed.
22 Can you tell me what's happening with
23 the #bFair2DirectCare money and why it hasn't
24 been disbursed?

1 COMMISSIONER KASTNER: Certainly.
2 We've been discussing -- the January 1st
3 increase of 2 percent for DSPs was
4 recommended by OPWDD. It was incorporated
5 into our rates, and then the rates are sent
6 up for approval and loading.
7 So you are correct, they have not yet
8 been received by our providers, but we do
9 expect they should be received in the near
10 future. I can't speak as to whether or not
11 that might occur after April 1st or not. But
12 we're committed to ensuring that those rates
13 go into force and that they are retroactively
14 paid back to January 1st.
15 SENATOR SAVINO: I'm not understanding
16 why, if it was supposed to go into effect
17 January 1st, why didn't it?
18 COMMISSIONER KASTNER: As I said,
19 they've been approved by OPWDD --
20 SENATOR SAVINO: They've been
21 approved, but they haven't been disbursed.
22 COMMISSIONER KASTNER: Correct.
23 Because we're not the sole entity responsible
24 for payment to providers.

1 SENATOR SAVINO: Would the other
2 entity be Medicaid?
3 COMMISSIONER KASTNER: Well, these are
4 Medicaid funds; it involves the Department of
5 Health, the Division of the Budget.
6 But I can tell you at our end we have
7 approved those rates and recommended that
8 they be paid. They will be paid retroactive
9 to January 1st.
10 SENATOR SAVINO: Will they receive
11 interest?
12 COMMISSIONER KASTNER: I can't speak
13 to whether or not that occurs. I --
14 SENATOR SAVINO: It's almost as if
15 we're -- you know, they're giving you guys an
16 interest-free loan. And I'm not putting you
17 on the spot, it's just -- you know, people
18 worked very hard to get that increase, and
19 it's just a little disconcerting to see that
20 while it's in statute, it's not actually in
21 operation. And these agencies operate on the
22 margins so often, as you know. And so it
23 just presents even more complications for
24 them as they deal with, you know, their own

1 issues.
2 So I would hope we would find a way to
3 do it faster. And I really do think we might
4 want to consider giving them the interest on
5 the money that they're owed.
6 COMMISSIONER KASTNER: We can
7 certainly go back and try to nudge that
8 process forward as quickly as we can. I
9 understand it's a cash-flow concern for
10 providers. I ran provider agencies --
11 SENATOR SAVINO: Yeah.
12 COMMISSIONER KASTNER: -- myself, and
13 I understand the margins are tight, that cash
14 flow is a problem.
15 SENATOR SAVINO: And again, not to put
16 you on the spot, but on January 1st the
17 minimum wage went up in this state. And so
18 part of this money was to help them meet
19 that. And so they're saddled with paying the
20 higher wage to their workforce, God bless
21 them -- in fact we want people to earn a
22 better living -- but they didn't get the
23 money to help them do that.
24 So I just think we should be a little

1 bit more aggressive about making sure they
2 get their money.
3 COMMISSIONER KASTNER: Well, thank
4 you. As I said, I'll go look at that.
5 SENATOR SAVINO: Thank you.
6 CHAIRWOMAN WEINSTEIN: Thank you.
7 We go to Assemblywoman Miller.
8 ASSEMBLYWOMAN MILLER: I have just two
9 other things that I wanted to ask. I'm
10 hearing a lot about individuals on
11 self-direction not having -- or the rumor
12 that they will not have full budget
13 authority. And it's frightening to hear
14 that.
15 Consumers have rights. Self-direction
16 allows individuals to integrate into the
17 community. They're gaining skills, making
18 progress to be more independent, with the
19 assistance of the comm-hab staff that I was
20 telling you before.
21 Isn't this the vision and mission
22 statement of OPWDD? And I quote: "Vision
23 Statement. People with developmental
24 disabilities enjoy meaningful relationships

1 with friends, family and others in their
2 lives, experience personal health and growth,
3 and live in the home of their choice and
4 fully participate in their communities."
5 The mission statement. We help people
6 with developmental disabilities live richer
7 lives. Isn't that the promise that we're
8 making to these constituents? I know it's
9 what I promised.
10 They want to know what happened to
11 choices. Taking away the full budget
12 authority within the regulations and
13 guidelines from the families and the brokers
14 will be devastating for them.
15 The other -- wait, before -- I'll just
16 ask them both at once and then you can just
17 answer.
18 Two years ago we enacted legislation
19 that created a new training program for first
20 responders to recognize and use appropriate
21 techniques to handle emergency situations
22 involving individuals on the autism spectrum
23 disorder. What's the status of that? And
24 has anything been developed, has anything

1 been implemented as of yet?
2 COMMISSIONER KASTNER: Sure.
3 Self-direction is an important tool for us in
4 helping families and individuals access the
5 services that they need. Last year alone, we
6 expanded the Self-Direction Program, added
7 3500 more individuals and their families to
8 the program, at a cost of approximately $100
9 million.
10 So we are committed to self-direction.
11 We currently spend about $400 million a year
12 and support 17,000, 18,000 individuals.
13 We're -- we're not talking about cutting it.
14 We're not talking about the loss of budget
15 authority.
16 ASSEMBLYWOMAN MILLER: You're just
17 giving the control to the CCMs {sic}, to the
18 care coordination agencies, rather than the
19 families and their brokers?
20 COMMISSIONER KASTNER: I -- I don't --
21 ASSEMBLYWOMAN MILLER: The CCOs are
22 already overwhelmed with the tasks that they
23 have.
24 COMMISSIONER KASTNER: Well, CCOs are

1 responsible for developing a life plan. That
2 is separate from a family working with a
3 fiscal intermediary or a support broker to
4 develop a plan of services to be delivered
5 through self-direction.
6 ASSEMBLYWOMAN MILLER: But the actual
7 control over the self-direction budget --
8 things change. It's fluid. It changes back
9 and forth. Where you don't use one thing, we
10 put it into another -- like we have the
11 ability to make it meet the needs of the
12 individual.
13 COMMISSIONER KASTNER: So families
14 have full budget authority, and they execute
15 that with --
16 ASSEMBLYWOMAN MILLER: And they're not
17 losing that.
18 COMMISSIONER KASTNER: We have no
19 plans at the current -- at this current time
20 to eliminate self-direction or full budget
21 authority.
22 ASSEMBLYWOMAN MILLER: Okay. Because
23 that was one thing that I keep hearing, that
24 they're taking the control and removing it

1 from the families.
2 Okay, thank you. And then the --
3 CHAIRWOMAN WEINSTEIN: Thank you.
4 ASSEMBLYWOMAN MILLER: Thank you.
5 CHAIRWOMAN KRUEGER: Senator Carlucci
6 for a second round.
7 SENATOR CARLUCCI: Thank you.
8 Commissioner, I know we've been asked
9 about the funding not coming through the door
10 yet. We've also heard that the July 2019
11 rates have not been approved either. Is that
12 true?
13 COMMISSIONER KASTNER: To your point,
14 the July 2019 rates were approved by OPWDD.
15 And similar to the January 1, 2020, rates,
16 they were presented, they need to be approved
17 and loaded and then paid. We recognize that
18 that's a hardship for our providers, and that
19 does affect their cash flow. And we're
20 working as effectively as we can to try to
21 get those funds made available to our
22 providers.
23 SENATOR CARLUCCI: Okay. And we're
24 also hearing that there will be a cut across

1 the board in July of this year. Can you tell
2 us about that? Do you know how much that cut
3 will be? And is that -- is that true?
4 COMMISSIONER KASTNER: The budget did
5 include a 2 percent across-the-board cut for
6 providers, that is true.
7 SENATOR CARLUCCI: Okay, so 2 percent
8 across the board.
9 And before, in the previous
10 conversation we had or testimony we had, we
11 talked about how 80 percent of the services
12 being provided by nonprofits, 20 percent by
13 state-run facilities. Can you tell us about
14 the cost of living adjustment or the trend
15 that we've seen? Is that provided equally to
16 state-run facilities as well as
17 non-for-profit facilities or operations?
18 COMMISSIONER KASTNER: Well, we've
19 talked a lot about the rates paid to
20 voluntaries for the services provided on
21 behalf of people with developmental
22 disabilities.
23 The state side of the operation is
24 funded based upon the collective bargaining

1 agreement. So I would defer to that document
2 and those negotiations for specific
3 information about the size of any increases
4 of salary or benefits.
5 SENATOR CARLUCCI: So are we saying
6 there's a difference between the COLA for
7 state and the COLA for nonprofit
8 organizations?
9 COMMISSIONER KASTNER: There probably
10 is. I don't know the specific nature of
11 that, but that would be a reasonable
12 assumption.
13 SENATOR CARLUCCI: Well, it seems that
14 there's been a deferred COLA on the
15 nonprofits but not for the state.
16 COMMISSIONER KASTNER: I'm sorry?
17 SENATOR CARLUCCI: The COLA has been
18 deferred for the nonprofits but not for the
19 state-run operations.
20 COMMISSIONER KASTNER: Well, as I
21 said, there is a deferral of the COLA for the
22 voluntaries. I don't know what the specific
23 parameters are of increases for state
24 employees under the collective bargaining

1 agreement.
2 SENATOR CARLUCCI: Okay. I wanted to
3 ask just -- this has come up. We see in the
4 Executive proposal that the -- there will be
5 the removal of the background checks for
6 health homes in the Executive Budget. And
7 you're talking about it's a duplication of a
8 background check.
9 Could you tell us more about that and
10 maybe tell us why that's necessary and what
11 that will do?
12 COMMISSIONER KASTNER: That is
13 applicable to health homes in general. The
14 health homes are operated by the Department
15 of Health. That falls outside of OPWDD's
16 scope, so I really can't comment on that.
17 SENATOR CARLUCCI: Okay. Since I have
18 just a minute left, I wanted to ask about
19 when we talk about children with autism, we
20 see a large spectrum. And I've been working
21 with parents particularly that are concerned
22 about high-functioning children with autism
23 and making sure that they have the
24 appropriate services.

1 Can you tell me what OPWDD is doing to
2 make sure that children with high-functioning
3 autism are getting the services that they
4 need?
5 COMMISSIONER KASTNER: Sure. One of
6 the strengths of OPWDD is that it's focused
7 on individuals and the planning is
8 individualized. And if you qualify for OPWDD
9 services, you actually access a wide range of
10 support and services. There are many
11 children, particularly individuals with
12 high-functioning autism, who can benefit from
13 services but may not qualify.
14 And in addition, we historically have
15 not been particularly strong at building
16 systems of care. So we're taking a lesson, I
17 think, from OMH and focusing on building a
18 continuum of services. We're looking at how
19 to engage pediatric providers, primary care
20 providers, and other healthcare professionals
21 to provide appropriate supports. We're
22 looking at building capacity among behavioral
23 health providers. We're also trying to
24 expand our access to intensive behavioral

1 services and, as I described in my testimony,
2 building out our network of crisis response
3 services.
4 We think there's a significant
5 opportunity to help children and their
6 families in particular access services which
7 might be more preventive in nature, as
8 opposed to reactive. I've heard the comments
9 about individuals in ERs and hospitals. We
10 want to try to avoid those when we can. So
11 being proactive, building systems that
12 support individuals would be very helpful in
13 that regard.
14 SENATOR CARLUCCI: Thank you,
15 Commissioner.
16 CHAIRWOMAN WEINSTEIN: Thank you.
17 We go to Assemblywoman Griffin.
18 ASSEMBLYWOMAN GRIFFIN: Thank you.
19 Good afternoon. I don't know if this
20 has been asked before, so forgive me if I'm
21 repeating. I know that the direct care
22 worker wages have increased by 4 percent, and
23 a 2 percent increase for clinical staff. But
24 I often meet with groups that work within

1 these groups, but they're not considered
2 direct care workers so they might not be
3 getting this wage increase.
4 And I wondered, are there known groups
5 that are excluded from being categorized as
6 direct care workers?
7 COMMISSIONER KASTNER: My
8 understanding of how the salary increases for
9 DSPs occurs is that there are certain types
10 of positions that are eligible for that
11 increase and others that are not. I mean,
12 clearly the focus is on supporting
13 individuals that have a direct care
14 relationship to individuals as opposed to
15 management in the nonprofits.
16 So we use certain position categories
17 to identify individuals that would be
18 eligible for that salary increase.
19 ASSEMBLYWOMAN GRIFFIN: Okay, thank
20 you. Yeah, it seems like there are -- you
21 know, I've met with -- I represent
22 southwestern Nassau County and I've been at a
23 couple of, you know, information meetings,
24 legislative breakfasts. And obviously it's a

1 very underfunded area. And there's so many
2 workers that -- you know, so many families
3 can't find people to work with their loved
4 ones because it's not well funded, like to
5 give them the adequate salaries. So it does
6 seem to, you know, to be an issue. So that
7 is something that I do question.
8 The other thing is I notice that we
9 have a cost-of-living adjustment that has
10 been deferred. So if the direct care workers
11 are getting an increase, who are the ones
12 that getting deferred from a cost of living
13 adjustment?
14 COMMISSIONER KASTNER: The salary
15 increases that were described earlier, the
16 January 1st and April 1st, are for DSPs. The
17 second increase is for DSPs plus clinical
18 staff. So the intent is to support the
19 capacity of organizations to provide services
20 directly to the individual, but the salary
21 increases are not focused on management.
22 ASSEMBLYWOMAN GRIFFIN: Okay. Okay,
23 thank you very much.
24 CHAIRWOMAN WEINSTEIN: Senate?

1 CHAIRWOMAN KRUEGER: Thank you. I'm
2 almost going to let you go. So someone asked
3 you before, but either I didn't understand
4 the answer or you didn't give the answer.
5 You have 150 agencies on a financial
6 watch list. Tell me what that means, give us
7 a list of the agencies -- send it to us --
8 and tell me what it means when you add a 2
9 percent cut in July.
10 COMMISSIONER KASTNER: As we
11 discussed, we are looking at our provider
12 capacity to ensure that it is adequate to
13 meet the needs of our individuals. The
14 current payment methodology to providers is
15 based on cost-based -- is cost-based, meaning
16 that the agencies send us a consolidated
17 fiscal report which identifies all of their
18 costs. All of those costs go into the rate
19 setting for that specific organization.
20 So there's a high degree of
21 variability for each agency in terms of the
22 rate that they're paid. We look at agencies
23 that may be fiscally stressed. We do not
24 want agencies to fail. We're particularly

1 concerned about agencies that have lower
2 costs, because they receive lower
3 compensation. Those are agencies that we do
4 want to support. There's no incentive for us
5 to allow them to fail, because if they fail
6 generally a higher-cost agency would assume
7 responsibility for providing those services.
8 So we're looking at opportunities to
9 try to enhance their operations and make them
10 viable.
11 CHAIRWOMAN KRUEGER: So you will be
12 able to provide us with a list of the 150
13 that are now on the watch list?
14 COMMISSIONER KASTNER: Of course.
15 CHAIRWOMAN KRUEGER: How many of them
16 went under last year?
17 COMMISSIONER KASTNER: I do not know.
18 CHAIRWOMAN KRUEGER: You don't know?
19 COMMISSIONER KASTNER: No, I don't
20 have that personal information. We can find
21 that for you.
22 CHAIRWOMAN KRUEGER: So if you could
23 follow up and also let us know how many went
24 under in the past 12 months.

1 COMMISSIONER KASTNER: Yes. Yes.
2 CHAIRWOMAN KRUEGER: I think that's
3 your time with us today. Thank you very much
4 for testifying.
5 COMMISSIONER KASTNER: Thank you,
6 Senator.
7 CHAIRWOMAN KRUEGER: Thank you. And
8 our next government witness, New York State
9 Office of Alcoholism and Substance Abuse
10 Services, Arlene González-Sánchez,
11 commissioner.
12 Good afternoon.
13 COMMISSIONER GONZÁLEZ-SÁNCHEZ: Good
14 afternoon, Senator Krueger, Assemblymember
15 Weinstein, Senator Harckham, Assemblymember
16 Rosenthal, and distinguished members of the
17 Senate and Assembly. My name is Arlene
18 González-Sánchez, and I'm the commissioner of
19 the New York State Office of Addiction
20 Services and Supports, or better known as
21 OASAS.
22 Thank you for providing me with the
23 opportunity to present Governor Cuomo's
24 fiscal year 2021 Executive Budget as it

1 pertains to OASAS. The Governor's Executive
2 Budget proposes that OASAS receive over $821
3 million, including $140 million for state
4 operations, $90 million for capital projects,
5 and $591 million for aids to localities.
6 The proposed Executive Budget will
7 enable us to continue funding our prevention,
8 treatment and recovery programs, including
9 the increase in minimum wage for OASAS-funded
10 providers as well as targeted salary
11 increases for support, direct care and
12 clinical staff.
13 The budget also supports increased
14 spending for capital projects consistent with
15 the agency's five-year capital plan,
16 including over 200 residential treatment beds
17 expected to open throughout the state over
18 the next three years.
19 The Executive Budget establishes a new
20 fund for the collection of fines levied for
21 violations of existing state and federal
22 behavioral health parity laws. Monies from
23 this fund would be used for initiatives
24 supporting further parity implementation,

1 including the ombudsman program.

2 The Governor has proposed legislation
3 to add 26 additional fentanyl analogs to the
4 state's schedules of controlled substances.
5 This is especially crucial in the fight
6 against the opioid epidemic, since the
7 majority of all overdose deaths in New York
8 State involve the use of substances
9 containing fentanyl.

10 We will continue to enhance access to
11 medicine-assisted treatment, increase
12 prescriber education and resources, and train
13 individuals in the use of naloxone as part of
14 our continued effort to combat the opioid
15 crisis.

16 Through our ongoing work, we are
17 making measurable progress. For the first
18 time in years we are starting to see a
19 reduction in opioid overdose deaths. We have
20 accomplished much of this progress through
21 our Centers of Treatment Innovation, or
22 COTIs, which offer expanded access to
23 substance use disorder services through
24 mobile treatment, telepractice and peer

1 services.
2 Counties served by COTIs have seen a
3 25 percent decline in opioid-related overdose
4 deaths and a 48 percent decline in opioid
5 overdose emergency department visits. So
6 this year we're expanding COTIs statewide.
7 Today we announced the availability of
8 funding to establish one mobile treatment
9 vehicle in each of the 10 Economic
10 Development Regions in New York, and to
11 develop telepractice capacity in every county
12 in the state.
13 We have also facilitated
14 collaborations between emergency departments
15 and OASAS-certified treatment programs to
16 enhance medical providers' ability to offer
17 MAT. EDs can begin induction on medication
18 to treat opioid use disorder, and with the
19 help of peers, provide a supportive
20 transition to ongoing treatment.
21 Another area that I would like to
22 highlight is our efforts to establish and
23 support MAT in state and local correctional
24 facilities. Currently MAT is offered in

1 11 state facilities and 52 county
2 correctional systems, including New York
3 City.
4 We are currently working with the
5 New York State Department of Corrections and
6 Community Supervision and the Department of
7 Health to implement a buprenorphine program.
8 Medical staff at the seven facilities have
9 received training on buprenorphine already.
10 This will permit individuals who are
11 maintained on buprenorphine while
12 incarcerated in county jails to continue
13 their treatment when transferred to state
14 custody.
15 OASAS also working closely with DOCCS
16 to initiate an OTP inside a correctional
17 facility. This would be the first
18 state-operated OTP in a correctional facility
19 in the country.
20 As we all know, recovery supports are
21 crucial. Over the past year, we have opened
22 18 new recovery centers, for a total of
23 32 recovery centers serving more than
24 50,000 individuals across the state. The

1 agency has also implemented a multifaceted
2 approach to prevention, reaching youth,
3 families and communities across the state
4 through classroom-based curriculums,
5 schoolwide environmental activities, and
6 individualized prevention support for at-risk
7 students.
8 All of these services would not be
9 possible without a dedicated SUD workforce.
10 At OASAS we are proactively finding ways to
11 support employees and staff. Last week we
12 announced the award of over $300,000 in
13 scholarship funding to support the
14 professional development of employees at
15 OASAS-certified organizations.
16 Finally, we continue developing public
17 education campaigns to address stigma, raise
18 community awareness about addiction, and
19 provide information on where to get help. In
20 2020 plans are underway to launch new
21 campaigns to address many common
22 misconceptions about addiction prevention,
23 treatment and recovery.
24 So as you can see, we have been

1 working on expanding and enhancing our
2 services across New York State. And under
3 Governor Cuomo's leadership, and with your
4 support, we continue to make an aggressive
5 push to confront the opioid crisis and save
6 lives. We look forward to your continued
7 partnership as we advance these priorities.
8 Thank you.
9 CHAIRWOMAN KRUEGER: Thank you.
10 Senator Pete Harckham.
11 SENATOR HARCKHAM: Thank you, Madam
12 Chair.
13 Commissioner, it's great to see you.
14 Thank you and your team for the great work
15 that you do.
16 Before I ask you a couple of
17 questions, just a statement -- and you don't
18 have to respond to this -- that many of us
19 and many of the people in the field think
20 that you are drastically underfunded. And so
21 I know that's not a question; you don't have
22 to respond to it. Those decisions are made
23 at a different pay grade. And I'm sure
24 you'll hear testimony from some of the

1 experts later on in the afternoon saying the
2 same thing.
3 So I just wanted to put out on the
4 record that for this Senator and for a number
5 of the Senators who could not be here, we
6 need to see your funding increased
7 drastically, and that's our job to do. So
8 thank you for all you do.
9 A couple of things. We spoke about
10 workforce issues with the other agencies.
11 The Senate was happy to partner with you on
12 the loan forgiveness, $300,000. Tell us how
13 that program is working, how it's been
14 received, and should we expand that.
15 COMMISSIONER GONZÁLEZ-SÁNCHEZ: It's
16 going tremendously well. As a matter of
17 fact, last week we announced -- I think it
18 was like 38 or 48 awards, which tells you
19 that it's really very much needed. People
20 really jumped on it. With this money, people
21 who are already or are thinking of becoming
22 licensed social workers or mental health
23 professionals will get additional help to pay
24 for the schooling as well as the certified

1 prevention.

2 So it's going tremendously well. It
3 was one of those initiatives that when we put
4 it out, immediately the response was
5 tremendous. So it's going really, really
6 well. And it's going to do a lot for our
7 workforce.

8 SENATOR HARCKHAM: Great. Switching
9 now briefly to the ombudsman program. It was
10 mentioned during another agency's testimony;
11 $1.5 million is the budget. If you would
12 explain to our constituents exactly what the
13 ombudsman program is and how many people it
14 serves.

15 COMMISSIONER GONZÁLEZ-SÁNCHEZ: Well,
16 as Commissioner Sullivan indicated, they've
17 served over 1600 cases already. It's boots
18 on the ground. There are five community
19 agencies right now that are funded through
20 the 1.5 that are actually doing the boots on
21 the ground helping individuals.

22 Again, it's another program that has
23 shown the tremendous need for this kind of
24 work in the community. And there are areas

1 of the state that we don't have a
2 community-based organization to assist
3 families.
4 SENATOR HARCKHAM: Right.
5 COMMISSIONER GONZÁLEZ-SÁNCHEZ: And I
6 see you have the map.
7 SENATOR HARCKHAM: Yeah.
8 COMMISSIONER GONZÁLEZ-SÁNCHEZ: And so
9 if we were to acquire additional dollars, we
10 would want to ensure that those areas that
11 are blanked, we could have a community-based
12 organization there to help individuals work
13 with these entitlement issues.
14 SENATOR HARCKHAM: All right. So this
15 is the map of the areas where we have gaps.
16 So the gray areas are where we have gaps, the
17 colored are the regions where we have
18 service.
19 So how much would it cost us to get to
20 fill in the entire state and cover all the
21 regions?
22 COMMISSIONER GONZÁLEZ-SÁNCHEZ: So
23 right now we're funding the existing ones at
24 $30,000, and there are five of them. What we

1 understand is that the funding is a little
2 low, so what we'd like to do is bring it up
3 to $50,000 and then fund additional CBOs at
4 that rate.
5 SENATOR HARCKHAM: Okay. And then the
6 thought, as explained to me, is that the
7 ombudsman program would go to $3 million,
8 with approximately $1.5 million coming from
9 the new ability of OFS to levy fines --
10 promulgate rules and levy fines against
11 insurance providers who are not guaranteeing
12 parity.
13 COMMISSIONER GONZÁLEZ-SÁNCHEZ: Yes,
14 it would be up to 1.5 if the appropriation is
15 approved and goes through.
16 SENATOR HARCKHAM: Okay. All right.
17 And then in your estimation -- let's
18 just say things work in a perfect world, that
19 part of the budget goes through. How long do
20 you think it takes for OFS to promulgate the
21 rules, people get up to speed, cases brought,
22 fines developed, and money starts flowing in?
23 COMMISSIONER GONZÁLEZ-SÁNCHEZ: Well,
24 like anything, it will probably take a little

1 time to get off the ground. So in the
2 interim, you know, we'll have to continue
3 working in the areas that we are. But it may
4 take a little while before fines are
5 promulgated and collected.
6 SENATOR HARCKHAM: So we're still
7 going to be short -- unless there's
8 legislative action, we're still going to be
9 1.5 shy from the 3.0.
10 COMMISSIONER GONZÁLEZ-SÁNCHEZ: Yes.
11 But, you know, I also want to make
12 clear just because we don't have a
13 community-based organization in those areas,
14 that we are not intervening when we're called
15 upon. It's just that it makes it more
16 difficult when you don't have, you know, CBOs
17 in particular areas. But we will continue --
18 SENATOR HARCKHAM: Right. And you've
19 got -- you've got the hotline, but that's
20 still not a 24/7. So in either case, we have
21 gaps that we need to fill.
22 COMMISSIONER GONZÁLEZ-SÁNCHEZ: Yes.
23 SENATOR HARCKHAM: Okay. Okay.
24 Moving on, a couple of other quick

1 things. We did a lot of traveling around the
2 state, as you know, the Senate did, in the
3 summer and in the fall, and we found out that
4 there were a lot of gaps. Gaps when people
5 leave hospitals, when they leave a
6 correctional facility, when they leave
7 treatment.
8 And one of the things that the federal
9 government has offered is funding of
10 take-home doses, up to a month. And that can
11 help sort of fill the gap in
12 medication-assisted treatment while we're
13 trying to get someone into their next.
14 New York's Medicaid reimbursement
15 model disincentives this. So what are we
16 doing to try and make this a more proactive
17 means of protecting people in the short term?
18 COMMISSIONER GONZÁLEZ-SÁNCHEZ: So as
19 you know, it is a complicated system, and
20 some of it is outside the jurisdiction of
21 OASAS. Nevertheless, we continue to work
22 with correctional facilities, with our
23 community-based organizations, to see how we
24 could minimize those risks of people being

1 released without medication, using our peers
2 and primarily our community-based, you know,
3 providers who assist us in being there and
4 helping us with this situation.
5 But it is a complicated system that
6 really falls outside of, you know, OASAS when
7 you're talking about Medicaid.
8 SENATOR HARCKHAM: Okay. All right.
9 I know we're going to run out of time soon.
10 I'm going to try and combine a bunch of
11 questions into one.
12 Criminal justice. You had mentioned
13 medication-assisted treatment in our
14 correctional facilities. A, want to know how
15 that is going.
16 B, we talk about criminal justice
17 reform. A lot of the sheriffs are saying,
18 Well, we no longer have that population to
19 treat. Obviously that's not where we want to
20 treat people, we want to get them first.
21 But what are the things that we can do
22 at the time of prearrest or arrest rather
23 than, you know, for that lower level
24 population?

1 And the third question is, what are we
2 doing to aid folks when they're getting out
3 of correctional facilities as a bridge?
4 Because we know that's -- those are among the
5 highest population for overdose deaths.
6 COMMISSIONER GONZÁLEZ-SÁNCHEZ: Okay,
7 so let's see how I figure this out. So let's
8 start off with we have 56 community-based
9 correctional facilities. And out of the 56,
10 45 are doing Vivitrol and 32 are doing
11 methadone and buprenorphine.
12 Now, on the state correctional side,
13 we have 52 prisons. All 52 are doing some
14 addiction services. Out of those 52, 11 are
15 doing medication-assisted treatment. Out of
16 those, four are doing Vivitrol and seven are
17 doing methadone. And soon, hopefully soon
18 they'll be doing buprenorphine as well.
19 So we have currently over 200
20 individuals behind the wall in state
21 facilities, including a handful of pregnant
22 women that are getting medication-assisted
23 treatment behind the wall.
24 On the community side, as I indicated,

1 we have those programs already providing
2 medication-assisted treatment. For those, we
3 continue to work with the sheriffs to look at
4 realigning some of the dollars that they got
5 to prescribe medication -- because the time
6 frame is so short now, to do more quick
7 assessment and referrals using peers.
8 We're also working with the various
9 DAs, you know, in Staten Island, here in
10 Albany, to do diversion programs at the point
11 in which police interact with the individual
12 prior to arraignment -- the HOPE program in
13 Staten Island, LEAD here.
14 So we are doing a lot of different
15 things on the community side to really
16 address this issue.
17 SENATOR HARCKHAM: Thank you.
18 CHAIRWOMAN KRUEGER: Thank you.
19 Assembly.
20 CHAIRWOMAN WEINSTEIN: We go to
21 Assemblywoman Rosenthal, chair of our
22 Alcoholism Committee.
23 ASSEMBLYWOMAN ROSENTHAL: Hi. Thank
24 you. Hello, Commissioner. Good to see you.

1 So we've heard how overdose deaths are
2 going down. But can you explain the
3 disparity in data between the DOH opioid
4 dashboard and the DOH county opioid quarterly
5 reports? And from the dashboard, it doesn't
6 appear to be any improvements in
7 opioid-related deaths in the state, yet it's
8 been said often that the number of
9 opioid-related deaths seems to be going down.
10 COMMISSIONER GONZÁLEZ-SÁNCHEZ: I
11 don't know that I'm prepared to discuss DOH
12 dashboard data. I don't know that I really
13 could do that. So I couldn't respond to
14 that.
15 ASSEMBLYWOMAN ROSENTHAL: Okay. So
16 assuming, yes, there's a reduction in
17 overdose death rates between 2017 and 2018 --
18 and I think a lot of them were in the City of
19 New York -- the pace of recovery is lopsided.
20 And we've not moved the dial for low-income
21 communities and communities of color, it
22 seems.
23 I have legislation to require that
24 naloxone be made available in homeless

1 shelters across the state, because every life
2 matters. Does OASAS have a program to
3 provide shelters with naloxone?
4 COMMISSIONER GONZÁLEZ-SÁNCHEZ: Well,
5 as you know, we do provide training, naloxone
6 training, and we do our own training. We
7 also, in collaboration with DOH, do that.
8 And when we do train folks, we have the
9 ability to give kits.
10 ASSEMBLYWOMAN ROSENTHAL: But I don't
11 believe that it's a requirement in all the
12 homeless shelters. And certainly people with
13 opioid use disorder are present in shelters
14 the way they are throughout society.
15 COMMISSIONER GONZÁLEZ-SÁNCHEZ: Right.
16 I don't believe it's required that they do
17 that. But I do know in some of the shelters
18 that we have both mental health and addiction
19 teams doing some work with individuals in the
20 shelter. I believe there's an offer and --
21 to give kits and also to train individuals,
22 to engage them in treatment.
23 But in terms specifically of Narcan
24 kits being given out, I really couldn't tell

1 you that that was a mandate, no.
2 ASSEMBLYWOMAN ROSENTHAL: Okay. So
3 along those lines, I'm the sponsor of
4 legislation requiring that
5 medication-assisted treatment be provided in
6 state and county correctional facilities as
7 well as, yes, state prisons.
8 The Governor announced in a State of
9 the State proposal that New York would seek
10 to have DOCCS recognized as an OTP. So while
11 it's good that the administration is
12 recognizing the importance of targeting the
13 vulnerable population with offers of MAT,
14 getting it recognized as an OTP will take a
15 long time.
16 It would be great if the
17 administration would consider expanding its
18 relationship with community-based OTPs so the
19 state correctional facilities can start
20 providing access to MAT now.
21 COMMISSIONER GONZÁLEZ-SÁNCHEZ: Well,
22 in fact there are some guest dosing that was
23 being done by our community-based
24 organizations at these different facilities.

1 And when DOCCS does get a program, then
2 they'll be able to do it on their own. But
3 for now it's through relationships with our
4 community-based organizations that they are
5 providing the methadone.
6 ASSEMBLYWOMAN ROSENTHAL: I don't
7 understand how anyone could justify not
8 providing buprenorphine, Vivitrol and
9 methadone -- all three -- in state prisons
10 where we know it's needed. Every single
11 prison, so that -- and in every county
12 facility as well. Because we know that
13 overdoses happen, we know that people
14 sometimes struggle to not be as dependent.
15 So if they had the buprenorphine, if
16 they had methadone, if they had Vivitrol for
17 those who want the one-month shot, that that
18 be given to them. I mean, they don't have
19 fewer rights in terms of healthcare just
20 because they're behind bars.
21 COMMISSIONER GONZÁLEZ-SÁNCHEZ: So
22 what I'd like to say -- first of all, you
23 know, I feel that I'm answering for the DOCCS
24 commissioner, and I want to make sure that I

1 don't do that. But from where I sit, I have
2 to say that I've seen a tremendous
3 partnership with DOCCS in the last couple of
4 years. I mean, the fact that we are in 11
5 facilities I think speaks a lot.
6 I think we need to also learn a little
7 more about the needs behind the wall: Do we
8 need 52 prisons to have all three
9 medications? I don't know. And I think this
10 is something we have to evaluate.
11 You have three reception centers that
12 they are opening that, you know, individuals,
13 once they are arrested and before they get
14 transferred to wherever they're going to do
15 their state time, will go. We have three
16 that they could continue their medication,
17 and now we have seven facilities.
18 I think we need to look at who we're
19 talking about. Are the numbers there to then
20 say we need to expand it to yet more prisons?
21 And I humbly say that's my opinion, and I
22 don't want to speak for the commissioner of
23 DOCCS.
24 ASSEMBLYWOMAN ROSENTHAL: Okay. Well,

1 the Assembly last year added $1 million to
2 the budget to expand MAT, but this funding
3 was not carried over into the 2021 budget.
4 So are there concerns that the funding, you
5 know, not being continued will affect the
6 pilot programs that are going on?
7 COMMISSIONER GONZÁLEZ-SÁNCHEZ: Well,
8 I have to say that yes, it wasn't carried on.
9 It was a one-time item, so the expectation
10 was not to carry it on.
11 However, I think that there are
12 efficiencies that we could look at. Like I
13 said, that we are looking, we are working
14 with the local sheriffs and police to see how
15 we could realign some of the dollars that are
16 in the county jails.
17 And so at this point I think that
18 there are concerns. I think that people are
19 working more closely together because of
20 other changes in laws. And we're watching it
21 carefully to see if they are.
22 ASSEMBLYWOMAN ROSENTHAL: I think this
23 is part of a game. Like you put it in the
24 budget, and I'll take it out, and then you

1 restore it.
2 But in this area, and I'll echo
3 Senator Harckham said, there's no room for
4 games here. I mean, it's a small budget and
5 the need is so great. We need to have Narcan
6 in every emergency room. We need
7 buprenorphine in every emergency room. We
8 need MAT available with counseling to people
9 behind bars. We need so much more. And this
10 petty -- you know, the Executive removes 2
11 million for SAPAS workers, the Assembly
12 restores it, now the Senate can join us in
13 restoring it. It's like games that shouldn't
14 happen in a budget that is dealing with
15 life-and-death issues.
16 And I wish that there was much more
17 money devoted to dealing with the overdose
18 crisis than there is right now.
19 Can you tell me how much federal money
20 OASAS has received this year?
21 COMMISSIONER GONZÁLEZ-SÁNCHEZ: Well,
22 we receive 111 million from -- for prevention
23 and treatment. And as part of the SOR, we
24 are receiving 35, I believe -- 32, 35

1 million.

2 ASSEMBLYWOMAN ROSENTHAL: And do we

3 know what we expect in the future?

4 COMMISSIONER GONZÁLEZ-SÁNCHEZ: The

5 SOR, the state -- well, the federal grant, we

6 expect the same amount unless there are some

7 cuts in Washington. The SOR is time-limited,

8 so this will be the last year that we get the

9 30 to 35 million that we're getting.

10 ASSEMBLYWOMAN ROSENTHAL: Okay. And

11 then I see time is running out, but I have

12 legislation on sober homes, three-quarter

13 homes, recovery homes, where people who are

14 newly in recovery go to find a supportive

15 environment in which to live.

16 But many in recovery homes are in

17 treatment looking for a stable living

18 environment. Sober homes are not typical

19 housing, and they are not treatment, so they

20 fall within a gray area. Someone who doesn't

21 have a safe and stable home in which to live

22 will find it much more difficult to maintain

23 their sobriety.

24 What does OASAS think its role is, or

1 should be, with respect to sober homes?
2 CHAIRWOMAN WEINSTEIN: And you'll have
3 an opportunity to answer that in the second
4 round.
5 ASSEMBLYWOMAN ROSENTHAL: Okay.
6 CHAIRWOMAN KRUEGER: Thank you.
7 Senator James Seward.
8 SENATOR SEWARD: Thank you, Madam
9 Chair. And thank you, Commissioner.
10 Following up on the discussion in
11 terms of what goes on in the local jails, I
12 know that the last two to three years this
13 has been a Senate priority, to include
14 $3.75 million for jail-based substance use
15 disorder treatment. Have these funds been
16 released from this year's budget? Or what's
17 your plan to implement this $3.75 million?
18 COMMISSIONER GONZÁLEZ-SÁNCHEZ: Oh,
19 no, the 3.75 is in the base. And yes, it's
20 been released. And that's what the local
21 jails and sheriffs are using to develop peer
22 programs and so on and so forth. It's very
23 well used, yes.
24 SENATOR SEWARD: Do you have a process

1 in place to evaluate the effectiveness of
2 these programs?
3 COMMISSIONER GONZÁLEZ-SÁNCHEZ: Of the
4 jail-specific ones?
5 SENATOR SEWARD: Right. Right.
6 COMMISSIONER GONZÁLEZ-SÁNCHEZ: We
7 have a process and -- we have a report that
8 we actually share with the Legislature on all
9 the new initiatives, like the recovery
10 supports, the clubhouses. And I believe the
11 report was sent either last week or today or
12 something -- I think last week.
13 With respect to the efficiencies or
14 the -- not efficiencies, but the outcomes of
15 the jail-based, we're continuing to work with
16 the sheriff associations to monitor the
17 outcomes. So we work with them. Do we get a
18 report? We're working on trying to get a
19 report from them.
20 SENATOR SEWARD: I would share the
21 concerns of my colleagues that the additional
22 $1 million for the MAT program in our local
23 jails is not included in the Executive's
24 proposal. And it's certainly, I think, a

1 much-needed program that hopefully we can
2 figure out a way to continue that.
3 You mention the reduction in heroin
4 overdoses here, and I've experienced that in
5 some of my counties as well. Would you say
6 that this is -- this phenomenon, and I think
7 it is a good trend to see. But is there a
8 way to evaluate whether that is because of
9 the expanded availability of Narcan? Or is
10 there just less use of heroin through, you
11 know, the treatment opportunities and the
12 like?
13 I mean, how can we judge whether it's
14 the Narcan or less use through treatment and
15 other means?
16 COMMISSIONER GONZÁLEZ-SÁNCHEZ: I
17 think it's a combination. And what we saw
18 early last year is that those counties,
19 especially upstate, where we implemented the
20 COTIs, the Centers of Treatment Innovations,
21 where we brought telehealth, we brought
22 mobile capacity to very, you know, rural
23 areas where there was no treatment, we saw a
24 drastic decrease in overdose deaths and even,

1 you know, emergency room visits.
2 So I think having that, the treatment
3 and the access to that -- remember, we've
4 also, through legislation, really increased
5 access by flexing some of our regulations.
6 We're out there training, you know, on
7 Narcan. I think it's a combination of all
8 that.
9 But certainly I think that, you know,
10 the mobile treatment has been key. And the
11 telehealth, it's been really, really
12 tremendous for our population.
13 SENATOR SEWARD: And one final
14 question, Commissioner. You know, as I read
15 the Governor's budget, the amount of funds of
16 approximately $240 million for
17 heroin/opioid-related funding of various
18 programs is flat. And could you share with
19 us how these funds will be utilized --
20 generally, obviously. You can't talk about
21 every single dollar -- but how these funds
22 will be utilized, and do you believe that
23 more funding would help combat even better
24 this heroin/opioid epidemic in New York

1 State?
2 COMMISSIONER GONZÁLEZ-SÁNCHEZ: Well,
3 what I could say is that there is a slight
4 increase in our budget, at least the
5 appropriated budget. The budget -- this
6 current budget does allow us to continue all
7 the work that we're doing, and yet some that
8 are in the pipeline, like I indicated, having
9 telehealth in every county, having the mobile
10 treatment in each county.
11 So this budget does allow me to
12 continue those efforts.
13 SENATOR SEWARD: Thank you.
14 CHAIRWOMAN KRUEGER: Thank you.
15 Assembly.
16 CHAIRWOMAN WEINSTEIN: Assemblyman Ra.
17 ASSEMBLYMAN RA: Thank you,
18 Commissioner.
19 I just had a question with regard to
20 the cannabis proposal. And I know there's
21 been obviously a lot of discussion about this
22 proposal publicly, it came up last year, and
23 there's an office that's going to deal with a
24 lot of the pieces of this.

1 But do you foresee, you know, any new
2 needs within your department as a result of
3 this adult use of marijuana potentially
4 becoming legal in New York State?
5 COMMISSIONER GONZÁLEZ-SÁNCHEZ: Well,
6 we will continue to work with DOH and the new
7 office. We treat cannabis abuse right now in
8 our system, and we will continue to do so.
9 It's premature to really say whether
10 we're going to see a spike or not, you know.
11 I can't really comment on that at this point.
12 ASSEMBLYMAN RA: Okay. And just -- so
13 with regard to that, so whether there should
14 be some piece of this, that some level of the
15 revenue goes toward treatment or anything
16 like that, you think it's premature until we
17 see, you know, what potential increase in use
18 we might see in New York State.
19 COMMISSIONER GONZÁLEZ-SÁNCHEZ: I
20 really can't comment on that because I think
21 those are negotiations that are happening
22 right now. So I really can't comment on that
23 point.
24 ASSEMBLYMAN RA: Thank you,

1 Commissioner.
2 CHAIRWOMAN WEINSTEIN: Senate.
3 CHAIRWOMAN KRUEGER: Thank you.
4 Senator David Carlucci.
5 SENATOR CARLUCCI: Thank you, Chair.
6 Thank you, Commissioner. It's great
7 to see you. And thank you for your
8 commitment to fighting addiction wherever it
9 is. And it's great to always see you in the
10 district, at openings. And my office has had
11 a great partnership with your office in doing
12 as many naloxone trainings as we can, and
13 we've trained hundreds of people, and they've
14 left with a kit. And every now and then I'll
15 be in the community, someone will come up to
16 me and say, Hey, I was at one of those
17 trainings, I had the kit, I used it, and I
18 saved someone's life. And you know, that
19 hits you. And it says, Okay, we've got to
20 keep doing this.
21 So one of the things I want to ask is,
22 is there something in the budget we can point
23 to that will be funding these naloxone kits
24 to make sure that the programs that you're

1 doing to distribute the kits free of charge
2 is continuing?
3 COMMISSIONER GONZÁLEZ-SÁNCHEZ: I
4 believe it is in our budget. I couldn't
5 really point it to you right now, but I'll be
6 more than glad to give you that information.
7 SENATOR CARLUCCI: But you're
8 satisfied that you're going to be able to
9 continue that program and provide free kits?
10 COMMISSIONER GONZÁLEZ-SÁNCHEZ: Yes.
11 Yes.
12 SENATOR CARLUCCI: Okay. Then I
13 wanted to ask about -- one of the things that
14 just drives me crazy is hearing about the
15 access to -- we've heard about
16 medical-assisted treatment and methadone.
17 And we know that the federal government has
18 allowed for take-home doses to exist.
19 But it seems that in New York State
20 that hasn't been as thorough or as accessible
21 as we'd like. I mean, I have people that I
22 know travel hours every day to get access to
23 methadone just to live an independent,
24 productive life. And we know -- we see our

1 corrections units going down the Thruway all
2 day long, or through our local roads, because
3 they don't have access to methadone locally.
4 What we've heard, though, on some of
5 the programs is that because of New York's
6 Medicaid reimbursement system, the way that
7 it's set up is that it disincentivizes the
8 take-home-dose program. As you know, it can
9 be 30 days that someone can have a take-home
10 dose, under the guidelines of the federal
11 government.
12 Can you speak to that? What are we
13 doing to make it easier? Is there something
14 that I'm missing? Is there a problem with
15 moving it in a way that would incentivize to
16 have more of these take-home dose options?
17 COMMISSIONER GONZÁLEZ-SÁNCHEZ: I
18 really feel uncomfortable speaking about the
19 whole Medicaid situation because that's
20 outside of our purview. That's more of a
21 Department of Health question. We continue,
22 as always, working with localities where
23 there is a need for medication-assisted
24 treatment. We're doing it via the vans, the

1 mobile vans. We're doing the best that we
2 can with what we can under our jurisdiction.
3 But when it comes to the whole, you
4 know, Medicaid billing and so on, I really --
5 I can't speak to that.
6 SENATOR CARLUCCI: Okay, I could
7 appreciate that.
8 With that said, we can't dive into
9 Medicaid, we don't have them here at the
10 table with us today. But are there other
11 roadblocks that you can see that we could be
12 proactive with under this agency to make
13 methadone more accessible in New York State?
14 COMMISSIONER GONZÁLEZ-SÁNCHEZ: Well,
15 we continue to move forward, you know, making
16 sure that our regulations speak to access,
17 individuals having access. I think that we
18 have really done a tremendous job in that.
19 We're continuing to work with
20 individuals and, you know, educating them
21 around medication-assisted treatment, and we
22 will continue to do that. I think that
23 there's still some gaps, some communities
24 that still don't understand that, you know,

1 buprenorphine is a medication. And that's
2 something that, you know, we need any help we
3 can in getting people to understand that it
4 is.
5 But like I said, you know, we continue
6 to work with the criminal justice system, the
7 judicial system, to get that across.
8 SENATOR CARLUCCI: So what would you
9 say, what is the biggest roadblock right now
10 for access to methadone in New York State?
11 COMMISSIONER GONZÁLEZ-SÁNCHEZ: I
12 don't know that I would say there's a
13 roadblock. I think we need to look at some
14 of our insurance payers. I think that's an
15 area we really need to look at. Because, you
16 know, people say it's a block, but it's
17 really the payers. So we need to do a better
18 job of talking to our private insurers as
19 well as Medicaid managed care plans.
20 SENATOR CARLUCCI: Thank you.
21 COMMISSIONER GONZÁLEZ-SÁNCHEZ: Thank
22 you.
23 CHAIRWOMAN KRUEGER: Assembly.
24 CHAIRWOMAN WEINSTEIN: Assemblywoman

1 Rosenthal.
2 ASSEMBLYWOMAN ROSENTHAL: Okay, thank
3 you. So in terms of sober homes, where I
4 ended last time -- and I've heard many
5 stories where they set their own rules. And
6 if someone, you know, comes two minutes late
7 then the management can say, Okay, you're out
8 of here. Or they say abstinence only, but
9 for a person who's on buprenorphine, that's
10 abstinence for them, they're not using heroin
11 or other opioids.
12 So -- and I have a bill to address
13 this issue. But what -- I think OASAS -- I'd
14 like to hear what you think the role should
15 be in terms of sober homes where people with
16 substance use disorder go.
17 COMMISSIONER GONZÁLEZ-SÁNCHEZ: Okay.
18 So this comes up every year. Sober homes, we
19 don't monitor -- our sober homes are not part
20 of our continuum of care. That's probably
21 part of the reason why there's so many issues
22 with sober homes.
23 We do have our own system of housing
24 within our portfolio. And I have in the past

1 said and I continue to say if you have sober
2 homes that want to be monitored and regulated
3 by OASAS, then, you know, they're welcome to
4 apply.
5 The -- you know, I can't -- I can't
6 tell a sober home that's not under our
7 purview to follow our regulations. I could
8 only do that with individuals that are
9 licensed under us. And that's the issue with
10 sober homes.
11 ASSEMBLYWOMAN ROSENTHAL: Okay. I
12 mean you correctly point out, because there
13 really is no oversight, that it's a free
14 reign to do whatever they want. And that
15 does need to change.
16 COMMISSIONER GONZÁLEZ-SÁNCHEZ: I
17 think that -- you know, to a certain extent I
18 also think that's a local issue that needs to
19 be addressed as well. Because some of these
20 entities, you know, are they zoned properly?
21 I mean, I really don't want to get into that
22 right now. But who monitors and who decides
23 I'm going to become a sober home, and how
24 does that happen?

1 ASSEMBLYWOMAN ROSENTHAL: Exactly.
2 Exactly. And the sober home creators do say,
3 Ooh, let me get your Medicaid money. And so
4 they have a certain responsibility back to
5 the state to not have these kinds of
6 frivolous power, you know, moves when a
7 person is in treatment or other
8 circumstances.
9 So the Governor vetoed a bill that I
10 cosponsored with Senator Harckham about prior
11 authorization. He did sign a bill that
12 commercial insurance would no longer have to
13 comply with -- would no longer have a prior
14 authorization issue, yet people on Medicaid
15 would still have to undergo prior
16 authorization. And at times that is going to
17 bollix up their whole treatment. Because
18 when a person needs their buprenorphine, for
19 example, there's no time to waste to wait
20 some days or even a week for prior
21 authorization.
22 How do you think that your agency or
23 others can attempt to make things right for
24 Medicaid patients?

1 COMMISSIONER GONZÁLEZ-SÁNCHEZ: So a
2 couple of things, a couple of comments.
3 Again, that's a DOH jurisdiction,
4 Medicaid.
5 But I just want to clarify that no one
6 will go without medication. I think that
7 what the Governor is proposing, this
8 standardized formulary would address a lot of
9 other issues that we're not talking about
10 when it comes to the formulary.
11 There are different forms of
12 buprenorphine. We have approximately 17 or
13 18, something like that, managed care
14 programs, right? Entities. They all cover
15 different forms of buprenorphine. It's
16 really chaotic . It's chaotic for the
17 person, the prescriber; it's chaotic for the
18 individual receiving the prescription.
19 Sometimes they go to their local pharmacy,
20 the pharmacy is not even stocked up.
21 So having a standardized formulary
22 where you have access, everyone's clear on
23 what forms of buprenorphine are covered by
24 the managed care entities, I think goes a

1 long way.
2 But I need to clarify: No one will go
3 without their buprenorphine. And if there is
4 -- I've got to finish. If there is an
5 individual that's on a particular form that
6 their managed care company does not cover it,
7 they have a -- we have in statute a five --
8 they could get five days of the medication,
9 and they also have a quick turnaround time
10 for prior approval. That's in statute as
11 well.
12 ASSEMBLYWOMAN ROSENTHAL: Thank you.
13 CHAIRWOMAN WEINSTEIN: Thank you.
14 Senate?
15 CHAIRWOMAN KRUEGER: Thank you. I'm
16 going to offer a few questions.
17 So I was very disturbed that you were
18 hypothesizing whether the number of people
19 having opioid overdoses was going up or down
20 statewide and whether it was the same people
21 having multiple -- and then Narcan or
22 something else saving them, or whether they
23 were unique independent overdoses.
24 So I'm going to ask you to submit a

1 document, a chart to the committees that
2 shows how many people had overdoses, how many
3 died, and whether -- if you know -- how many
4 multiples there were of the same people, that
5 the success of having access to Narcan
6 treated them.
7 Because in your testimony you talk
8 about in the counties where you have X
9 operating -- and then Pete Harckham had a map
10 that showed holes in the counties. But I
11 think we really want to know county by county
12 what the story is and whether we're going up
13 or down.
14 COMMISSIONER GONZÁLEZ-SÁNCHEZ: So can
15 I clarify?
16 CHAIRWOMAN KRUEGER: Yup.
17 COMMISSIONER GONZÁLEZ-SÁNCHEZ: The
18 map that Senator Harckham had had nothing to
19 do with overdose deaths.
20 CHAIRWOMAN KRUEGER: Okay.
21 COMMISSIONER GONZÁLEZ-SÁNCHEZ: It had
22 to do with the ombudsman program.
23 And I did not hypothesize of whether
24 the deaths are going up or down. As a matter

1 of fact, I didn't want to comment on a
2 Department of Health database because I don't
3 have that data to comment on. I don't -- I
4 didn't hypothesize that the numbers are going
5 up or down. In fact, in some areas they are
6 going down and in some areas they're
7 plateauing and in other areas they're just
8 going up slightly.
9 CHAIRWOMAN KRUEGER: So you do have
10 that data available.
11 COMMISSIONER GONZÁLEZ-SÁNCHEZ: Yes.
12 And the data that I have -- let me be
13 clear -- I also work with the Department of
14 Health to get. Because they're the ones that
15 have that data. They get it from the
16 hospitals. That's the only way I would be
17 able to get that data.
18 CHAIRWOMAN KRUEGER: Well, if you
19 died, they would get it from the hospitals,
20 perhaps. But if you were saved and never
21 even got to a hospital, it wouldn't be
22 hospital data.
23 But I think you're right, that the
24 Department of Health should still have that

1 data in their data collection. But you
2 should also have easy access to that kind of
3 data.
4 COMMISSIONER GONZÁLEZ-SÁNCHEZ: Yeah.
5 CHAIRWOMAN KRUEGER: And then you were
6 asked several times -- and I'm just totally
7 confused. Federal law says that they can
8 give you Medicaid if you are moving,
9 transitioning from one program or jail to
10 somewhere else so that you don't have an
11 interruption in medications that are helping
12 ensure you don't go back to the kinds of
13 drugs we don't want you on. And you've said
14 several times you can't comment about how DOH
15 handles this.
16 You have many sort of arrangements
17 with the Department of Health where you do
18 things together. I remember when you were
19 going through and moving methadone clinics to
20 being full health clinics so that people who
21 were going for methadone were getting full
22 healthcare at the same sites, because that
23 was very rational.
24 What is it that prevents the State of

1 New York from making sure that people can
2 continue medication uninterrupted so that
3 they don't find themselves perhaps up to 30
4 days with no access to medications that we
5 know they were on and are working?
6 COMMISSIONER GONZÁLEZ-SÁNCHEZ: So I
7 guess I would rephrase my answer by saying
8 that I would need to discuss with the
9 Department of Health to see what are the
10 issues, if any, preventing us from doing
11 that.
12 But right now I'm not -- I'm not
13 prepared to respond to the specifics of that.
14 CHAIRWOMAN KRUEGER: But these are
15 people coming out of where?
16 COMMISSIONER GONZÁLEZ-SÁNCHEZ:
17 Prison.
18 CHAIRWOMAN KRUEGER: Prison? So when
19 they're in prison, we know everything about
20 them. We've got all the I.D., we've got
21 every piece of information. And there
22 certainly are models where people are signed
23 up for Medicaid while they're still pending
24 release from prison. We've had that model in

1 a variety of places throughout the state.
2 So pretty much it's exclusively when
3 you're leaving prison and we know you have
4 been in a drug program where you're getting
5 medicine, and we wanted to make sure you
6 continue that medicine. Right?
7 COMMISSIONER GONZÁLEZ-SÁNCHEZ: Right.
8 CHAIRWOMAN KRUEGER: Okay. It may
9 take DOH cooperation, it may take DOCCS
10 cooperation. But this seems to me to be a no
11 brainer and that we want to make sure we're
12 not leaving people hanging out there for 30
13 days without the treatment that they have
14 been responding well to. Because you're
15 setting them up for a couple of things.
16 One, you're of course setting them up
17 to go back to their addiction problem. And
18 two, you're likely setting them up to just
19 get sent right back to the state jails
20 because they've flunked the test of sobriety.
21 So it just seems, again, this is a
22 win/win or a lose/lose, and we're currently
23 in the lose/lose column. So I hope that we
24 can move to the win/win column quickly.

1 Another follow-up question -- and Pete
2 Harckham raised it, and I think Linda
3 Rosenthal raised it -- just the inadequacy of
4 enough money for drug treatment. You and I
5 have talked about in the past the problem we
6 see in New York City where you're on the
7 streets, you haven't been open to going into
8 shelter, you are very often a dual mental
9 illness and substance-abusing person, and
10 suddenly because of the work of the outreach
11 teams, usually, the person says, "You know
12 what, yeah, it's time, I need help, I need
13 treatment." And they need to get them
14 residential treatment right away.
15 And we even had a meeting maybe two
16 years ago now with your team and the city's
17 HRA and homeless services team and I think
18 Department of Mental Health, and you had a
19 number of programs that were just about to
20 open and were going to help address this.
21 Did they open?
22 COMMISSIONER GONZÁLEZ-SÁNCHEZ: Are
23 you talking specifically for the teams in the
24 shelters?

1 CHAIRWOMAN KRUEGER: You had a number
2 of different programs. But you also were
3 committing to more residential on-demand for
4 people who were on the streets with a
5 combination of substance abuse and mental
6 illness.
7 COMMISSIONER GONZÁLEZ-SÁNCHEZ: Well,
8 we do have a couple of programs that have
9 opened up throughout the state to do exactly
10 that. I don't have the list -- I don't
11 remember the list. But I'll be more than
12 glad to submit it to you and tell you when
13 they started, how they're doing, how many
14 people they're serving, and so on and so
15 forth.
16 CHAIRWOMAN KRUEGER: Okay. That would
17 be appreciated, thank you.
18 Assembly?
19 CHAIRWOMAN WEINSTEIN: Assemblywoman
20 Gunther.
21 ASSEMBLYWOMAN GUNTHER: So I have a
22 question regarding -- I was in a clinic in
23 Newburgh. And, you know, there's -- people
24 fail on the other meds and often they stay on

1 methadone, you know. And you have to go to a
2 clinic in order to get methadone.
3 And yet what my understanding is is
4 that, you know, people travel from all over
5 the Orange County area to get to this clinic.
6 And they also, you know, usually in those
7 facilities they have ID doctors, just general
8 practitioners. And there's an issue with
9 one-stop shopping for those folks.
10 Like, in other words, it has bathroom
11 issues -- it's like some ridiculous thing
12 that is stopping somebody to do their deal
13 and get what they need to remain sober, but
14 also going then on the -- maybe to the other
15 side and getting medical care, like if
16 there's an ID doctor and you have a
17 co-infection with HIV or something like that,
18 that you can't go from one side to the other.
19 Whether it's one bathroom missing -- it's
20 like ridiculous rules that the DOH has in
21 place that are preventing people from
22 one-stop shopping.
23 We're spending a boatload of money on
24 Medicaid cabs and -- because you come for one

1 reason and then you go to someplace else for
2 another reason.
3 So it's a cost saving and it's also
4 something that when you have a captive
5 audience, you really get to be able to do a
6 thorough, you know, full-person evaluation.
7 And there's a remarkable thing called like
8 talking to one another between like an ID
9 doctor, someone that's running the program,
10 et cetera, et cetera.
11 And there's something that's stopping
12 it, and I don't know what exactly the law on
13 the books is. But I know that it would be
14 much more cost-efficient, it would be better
15 for the patient, it's more of a holistic
16 approach in 2020.
17 And if you could look and see what we
18 can do to maybe change that system. Because
19 I think it's important -- I know that
20 anonymity for many is very important. But
21 again, you walk in with a tribunal of people
22 from all different walks of life -- there can
23 be, you know, the president and CEO and
24 somebody else.

1 So I just thought I'd bring it to your
2 attention because New York could save money
3 on Medicaid cabs and it's also a convenience
4 for many that are, you know, getting
5 treatment. And also because of, you know,
6 brutalizing their body for some time, they
7 have to make sure that their health is in
8 good order.
9 That's all I have to say.
10 COMMISSIONER GONZÁLEZ-SÁNCHEZ: Thank
11 you.
12 ASSEMBLYWOMAN GUNTHER: I just went
13 there. That's why I brought it up.
14 CHAIRWOMAN KRUEGER: Senator Pete
15 Harckham, second round, to close.
16 SENATOR HARCKHAM: Thank you,
17 Madam Chair.
18 So many questions, so little time.
19 I'm glad Chair Rosenthal asked about housing,
20 we'll check that off the list.
21 Let's talk about harm reduction. Over
22 the last couple of months as we traveled
23 around the state, we heard so much about, you
24 know, before you get people in treatment,

1 we've just got to keep people alive and reach
2 them where they are, wherever that may mean.
3 Anything from needle exchange all the way to
4 supervised consumption.
5 So what is the state doing, what are
6 we doing now in terms of harm reduction, and
7 what opportunities do we have to do more?
8 COMMISSIONER GONZÁLEZ-SÁNCHEZ: So as
9 you know, we have, you know, flexed our
10 regulations. There's no wording in our regs
11 that says "abstinence only." We're very
12 patient-centered in everything we do. We
13 work with the individual where they're at.
14 We don't force treatment on anyone. We work
15 with them. And we will continue to do that.
16 SENATOR HARCKHAM: Any specific
17 programs? That's kind of a generic
18 philosophy. I guess what I'm looking for,
19 what more can we do, particularly in our
20 hard-to-reach communities, in terms of
21 keeping people alive and harm reduction?
22 COMMISSIONER GONZÁLEZ-SÁNCHEZ: Well,
23 you know, we're out, we have peers out in the
24 street doing one-on-one work with

1 individuals, with Narcan, trying to get them
2 into treatment if that's what they want. And
3 we're going to continue to do those efforts.
4 SENATOR HARCKHAM: All right. Thanks.
5 One of the other things that we hear
6 and see is the shortage of doctors who have
7 the waiver for -- to prescribe certain types
8 of medication-assisted treatment. What are
9 we doing to try and incentivize more
10 physicians, physician assistants and nurse
11 practitioners into the program?
12 COMMISSIONER GONZÁLEZ-SÁNCHEZ: Well,
13 I hear that often. Last year it was the same
14 issue. I'm not sure that's accurate. I
15 think we have quite a few ex-waivered
16 physicians. I think the issue is whether
17 they want to prescribe or not. That's
18 another issue.
19 We now, of course, are working with
20 DOH to ensure that the EDs start induction of
21 medication-assisted treatment and then
22 communicate with the community-based
23 organizations to hook up the individuals if
24 they at the emergency rooms cannot or do not

1 want to prescribe.
2 So we should have a better sense this
3 year, once these things are fully implemented
4 and we have the appropriate oversight to know
5 how that's working. But we continue to work
6 with physicians who want to be waivered. I
7 believe we do a -- we have even assistance in
8 doing the actual waiving, the teaching and so
9 on and so forth, and we will continue that.
10 SENATOR HARCKHAM: All right.
11 Speaking of the emergency rooms, we had heard
12 from patient advocacy groups and treatment
13 providers there are still emergency rooms in
14 the state that don't have MAT-qualified
15 physicians in the emergency room.
16 I know you're rolling that out, you've
17 got a program for that. How soon before we
18 close that gap and literally every emergency
19 room in New York State has at least one
20 MAT-certified physician?
21 COMMISSIONER GONZÁLEZ-SÁNCHEZ: So as
22 I indicated, we will continue to work with
23 the Department of Health, because they're the
24 ones that have jurisdiction over hospitals,

1 to ensure that that happens.
2 But that is part of regulations right
3 now, and they have to do discharge planning,
4 that's appropriate, and they must start
5 induction in the EDs. We need that
6 oversight. So I will continue to work with
7 the Department of Health to ensure that that
8 happens.
9 But there are several EDs that are
10 doing it already.
11 SENATOR HARCKHAM: Terrific. Thank
12 you.
13 Thank you, Madam Chair.
14 CHAIRWOMAN KRUEGER: Thank you. I
15 think we're done. Thank you very much.
16 COMMISSIONER GONZÁLEZ-SÁNCHEZ: Thank
17 you.
18 CHAIRWOMAN KRUEGER: And our next
19 testifier is Denise Miranda, executive
20 director of New York State Justice Center for
21 the Protection of People with Special Needs.
22 EXECUTIVE DIRECTOR MIRANDA: Good
23 afternoon, Chairs Krueger, Weinstein,
24 Carlucci, and Gunther, as well as other

1 distinguished members of the Senate and
2 Assembly.
3 My name is Denise Miranda, and I am
4 the executive director of the New York State
5 Justice Center for the Protection of People
6 with Special Needs. I would like to thank
7 you for the opportunity to testify regarding
8 Governor Cuomo's Executive Budget proposal.
9 Today I come before you on behalf of
10 the more than 1 million New Yorkers in care
11 with special needs. The Justice Center's
12 work is directed by our steadfast commitment
13 to protecting vulnerable people from abuse
14 and neglect. It is our commitment to that
15 focus that drives every aspect of what we do
16 and every decision that we make.
17 We refuse to deviate from our mission
18 because history has proven that this opens
19 the door to bad actors who for years worked
20 the system while hurting people.
21 CHAIRWOMAN KRUEGER: Denise, pull the
22 mic a little closer to your mouth, sorry.
23 Thank you.
24 EXECUTIVE DIRECTOR MIRANDA: Sure.

1 Thanks to the leadership of the
2 Governor, and with your partnership, cases
3 that previously had fallen through the cracks
4 are now fully investigated and those
5 responsible for abuse and neglect are held
6 accountable.
7 Nearly seven years ago, the Justice
8 Center was tasked with the important mission
9 of protecting vulnerable populations, and we
10 have learned a lot in that time. Some look
11 at the young age of this agency as a
12 detriment. I see it as an advantage.
13 Because we are young, we are not entrenched
14 in how we operate. Our processes are still
15 evolving.
16 Every day we work at evaluating where
17 we can be more efficient and build
18 collaboration both inside and outside of the
19 agency. Time and time again, we search for
20 better ways to serve individuals, families
21 and stakeholders.
22 In our continual pursuit to build and
23 improve the Justice Center, we recognized a
24 need to renew our focus on one of our largest

1 and most critical units -- investigations.
2 We're getting back to the basics. The agency
3 has implemented a new, intensive on-boarding
4 and mentorship program for all new
5 investigators. The program provides the
6 resources they need as they learn to navigate
7 these very complex cases.
8 In the past 12 months, we have
9 continued to explore new and better ways to
10 serve those we protect. The Justice Center's
11 sexual abuse response team is now fully
12 operational. This cross-disciplinary group
13 is highly trained in the latest investigatory
14 techniques and strategies. Our team takes a
15 trauma-informed approach so that individuals
16 will not be revictimized. Creating a cohort
17 that has been trained by nationally
18 recognized experts ensures our ability to
19 bring justice to the victims and hold bad
20 actors accountable.
21 But investigating allegations is only
22 one part of what we do. Our prevention work
23 continues to expand. More than 350
24 corrective action plan audits, 40 site

1 visits, and a dozen systemic reviews were
2 conducted in 2019 to ensure providers are
3 taking appropriate steps to stop abuse and
4 neglect before it happens.
5 We continue to collaborate with our
6 state oversight agency partners on the
7 Interagency Abuse Prevention Workgroup, but
8 this year we're going even further. Recently
9 the Justice Center established its own
10 internal workgroup solely focused on
11 developing new prevention initiatives. We
12 also introduced an in-person training for
13 providers and staff on establishing
14 professional boundaries.
15 This past year we added a new toolkit
16 to our growing library of prevention
17 resources: "The Dangers of Intestinal
18 Obstructions." Justice Center data
19 highlighted this as a serious, sometimes
20 life-threatening issue for individuals
21 receiving services. In addition, a toolkit
22 featuring guidance on wheelchair securement
23 will be coming out this year.
24 Engagement with stakeholders remains

1 an ongoing need for the agency. This has
2 been a priority since my arrival three years
3 ago. In 2019, we focused on helping
4 organized labor understand our role in the
5 workplace. We engaged in several sessions
6 around the state with members of unions to
7 share information about the Justice Center.
8 Outreach to providers and families has
9 also been a top priority. The Justice Center
10 held five regional conferences throughout the
11 state in 2019. These free, day-long events
12 gave attendees the opportunity to gain
13 in-depth knowledge of the agency. The
14 conferences continue to open the dialogue
15 between the Justice Center and those we
16 serve.
17 Another way the Justice Center
18 supports individuals and families is through
19 our advocates. Our team assisted more than
20 4,000 people last year and provided
21 accompaniment services to more than
22 400 people during interviews. We also helped
23 hundreds of families access investigatory
24 records. As a result of their hard work, we

1 received additional grant funding and we were
2 able to grow our staff of advocates in our
3 high-volume areas.
4 Last but not least, we continue to
5 build on our established foundation of
6 collaboration with our state oversight agency
7 partners. The Justice Center now holds
8 monthly meetings with each state oversight
9 agency.
10 We believe the work we have planned in
11 the coming year will continue to improve the
12 Justice Center. The safety and well-being of
13 the individuals under our jurisdiction
14 remains the foundation of everything we do.
15 We do not deviate from this mandate, but we
16 seek opportunities to enhance it in any way
17 we can.
18 Thank you.
19 CHAIRWOMAN KRUEGER: Thank you.
20 Our chair, David Carlucci.
21 SENATOR CARLUCCI: Thank you.
22 Thank you, Commissioner, Director.
23 Appreciate your testimony here today and the
24 work that you've done.

1 So just quickly, one of the things I
2 wanted to make sure I asked you about was the
3 change in the budget about the optional
4 statewide central registry. And this is
5 something that, after reading, is just
6 difficult to explain to my colleagues and to
7 advocates about what is being done here.
8 Can you tell us why this change is
9 necessary and how the concern is that it will
10 -- that it won't lead to adverse outcomes?
11 EXECUTIVE DIRECTOR MIRANDA: Sure,
12 absolutely. And I appreciate the question
13 because I know this issue has been a source
14 of some confusion.
15 The SCR checks are part of our
16 criminal background check for pre-employment
17 purposes. Those checks are going to remain
18 in place as they are. The proposal that's
19 before us contemplates eliminating the need
20 for the SCR checks to be mandatory when
21 they're part of an investigation.
22 So this is not going to have any
23 impact in terms of qualifications, background
24 checks, et cetera, but it's really an

1 investigatory stage of our cases where
2 currently we are mandated to do an SCR check.
3 The changes in the proposal still
4 allow for that check to be discretionary if
5 we choose to do so, but what we've found is
6 that the SCR does not provide any value
7 evidentiary-wise from the perspective of
8 assisting us in our investigation. Our
9 investigation is limited to the four corners
10 of the allegations that are before us, and
11 the SCR is, frankly, drains on resources that
12 we have and we believe that it should be
13 discretionary, not a mandatory requirement.
14 SENATOR CARLUCCI: And can you
15 elaborate why it is a drain on resources?
16 What's entailed here?
17 EXECUTIVE DIRECTOR MIRANDA: Sure. So
18 we're talking about two to three hours for
19 every single SCR check, which is a
20 considerable amount of time, again,
21 considering the weight that it will have and
22 the bearing it will have on an investigation.
23 The SCR check, as many of us know,
24 there have been a lot of concerns regarding

1 the SCR check. There are allegations that
2 date back 20 years. And so from the
3 perspective of deciding whether an allegation
4 of abuse and neglect has occurred, whether we
5 can substantiate or unsubstantiate, the SCR
6 does not help us build evidence in a case.
7 SENATOR CARLUCCI: Okay. And so how
8 often are you accessing that in a given year?
9 EXECUTIVE DIRECTOR MIRANDA: So for
10 every single investigation that we do, we're
11 currently required to run an SCR check for
12 the subject involved in that investigation.
13 So currently right now we're talking about,
14 last year, 12 to 13,000 investigations. So
15 it is a real impact on the agency and our
16 ability to function.
17 SENATOR CARLUCCI: And what do you
18 think that will -- so if we're going from 12
19 to 13,000 a year, what will that bring it
20 down to, you think?
21 EXECUTIVE DIRECTOR MIRANDA: Well, as
22 I mentioned before, it's discretionary.
23 Right? And so if in the rare instance we
24 find that this would be particularly helpful,

1 we still have the ability to make that check.
2 You know, again, I think a lot of the
3 concern regarding the SCR check has been
4 conflated with our background check process.
5 That will remain in place. The SCR will
6 still be part of the employment clearance
7 process.
8 SENATOR CARLUCCI: And so what do you
9 think -- what's your estimate in terms of if
10 it's not mandatory, it's discretionary, how
11 often -- will it be 50 percent of the time, 1
12 percent of the time?
13 EXECUTIVE DIRECTOR MIRANDA: That's
14 going to depend on the investigations. Every
15 single investigation is unique. We look at
16 those cases individually. So I cannot at
17 this particular point hazard a guess with
18 respect to how often we would use the SCR.
19 What we have found thus far, with
20 close to 70,000 investigations done since the
21 opening of our agency in 2013, it has not
22 proven to be helpful in terms of building a
23 case of abuse or neglect or coming to a
24 determination that a case should be

1 unsubstantiated.
2 SENATOR CARLUCCI: So from this it
3 sounds like you would maybe never use it?
4 Like when -- I'm just trying to understand
5 when you would use this check.
6 EXECUTIVE DIRECTOR MIRANDA: It will
7 remain discretionary. And we will evaluate
8 every single case to determine if it's
9 necessary. And if it's there, that resource
10 will be available.
11 SENATOR CARLUCCI: Okay. Now, you
12 mentioned that you've taken on 70,000
13 investigations since the start of the Justice
14 Center seven years ago.
15 EXECUTIVE DIRECTOR MIRANDA: Correct.
16 SENATOR CARLUCCI: And what -- can you
17 tell us, is there an agency that you have
18 more cases out of than any other? Can you
19 tell us that? And then have you seen a trend
20 in terms of newer types of cases that you're
21 getting? Could you speak to both of those
22 issues?
23 EXECUTIVE DIRECTOR MIRANDA: Sure.
24 So currently our cases, approximately

1 50 percent of those cases are related to the
2 state oversight agency of OPWDD. That does
3 represent the bulk of the investigations that
4 we do.
5 We're constantly analyzing our data to
6 identify trends. These trends help inform
7 our prevention tools that we create every
8 single year. As I mentioned in my testimony,
9 we do a "Spotlight on Prevention." We've
10 done six of these. A lot of the
11 determination of what the topic will be.
12 It's based on the trends of what we're seeing
13 in terms of investigations and allegations
14 that are coming in.
15 So we've created spotlight kits on
16 intestinal obstruction, we have another one
17 that will be forthcoming on wheelchair
18 securement, we've done one on caregiver
19 fatigue, safety for individuals left in
20 vehicles, and another one on restraints, on
21 how to eliminate or diminish the occurrence
22 of restraints.
23 So all of those topics are based on
24 the data that we're seeing in terms of the

1 number of cases that are coming in, and we
2 continue to review that data every year to
3 help inform our choices.
4 SENATOR CARLUCCI: Okay. So you
5 mentioned those six categories. I'm just
6 trying to follow you here. So you had the
7 wheelchair constraints -- that is a report
8 that you're putting out or --
9 EXECUTIVE DIRECTOR MIRANDA: So
10 wheelchair securement. What we've seen is a
11 trend in individuals being injured because
12 they have been improperly fastened within a
13 vehicle. Right? And so this is a real
14 concern, because those injuries can be quite
15 serious if a person is not appropriately
16 secured, especially in a moving vehicle. And
17 so that has informed our decision to make
18 sure that we're creating a toolkit which will
19 be released this year.
20 All of this information is available
21 on our website. Our toolkits, besides
22 education and resource materials, there's
23 also a lot of material there for providers in
24 terms of self-assessments as well.

1 SENATOR CARLUCCI: So you would say
2 that -- the question was about trends that
3 you see, and the response is that there's
4 these toolkits that are put in place when you
5 do see a trend. Is that what I can gather?
6 EXECUTIVE DIRECTOR MIRANDA: That's
7 correct.
8 SENATOR CARLUCCI: Okay. And so what
9 were some of the other ones that you were
10 talking about? I got confused with the
11 regional meetings that you're doing to do
12 outreach and educate the workforce, and then
13 the trends that you're seeing. So you've got
14 the wheelchair restraints --
15 EXECUTIVE DIRECTOR MIRANDA: So the
16 topics of the Spotlight?
17 SENATOR CARLUCCI: Yeah, like --
18 EXECUTIVE DIRECTOR MIRANDA: Reduction
19 of restraints --
20 SENATOR CARLUCCI: -- what I'm trying
21 to understand is what you're seeing, because
22 you're seeing 10, 12 to 13,000 cases a year,
23 and what -- are there any types of things
24 that we should be concerned about or know

1 that have been changes in the past seven
2 years? Things that you see that are
3 increasing in more frequency.
4 EXECUTIVE DIRECTOR MIRANDA: So with
5 respect -- besides the Spotlight on
6 Prevention, right? Which as I discussed,
7 those topics are based on the data and the
8 trends that we're seeing of abuse and
9 neglect.
10 We also have a very consistent data
11 point with respect to the cases that are
12 substantiated. Approximately 75 percent of
13 our cases are substantiated at Category 3.
14 Category 3 is our lowest category for abuse
15 and neglect. That statistic has held
16 consistent for the past six years.
17 So what we see there is thankfully a
18 couple of things. Number one, there's a low
19 rate of criminality within the service
20 settings, which is a good thing. The
21 majority of the cases that we do investigate
22 are Category 3 and, thankfully, not the most
23 egregious cases, although those certainly do
24 occur and we have those cases within our

1 jurisdiction.

2 But in terms of category level
3 seriousness, you know, those are the trends
4 that have been quite consistent now for six
5 years.

6 SENATOR CARLUCCI: Okay, thank you.

7 Thank you, Chair.

8 CHAIRWOMAN KRUEGER: Thank you.

9 Assembly.

10 CHAIRWOMAN WEINSTEIN: Assemblywoman
11 Gunther.

12 ASSEMBLYWOMAN GUNTHER: Can you give
13 us a little bit of an update where you are
14 with the lawsuit relating to the independent
15 prosecutor?

16 EXECUTIVE DIRECTOR MIRANDA: Yes. So
17 currently that issue will be before the Court
18 of Appeals. As many of you may recall, the
19 issue here is the independent authority of
20 the agency to have a prosecutor. There's
21 nothing in the State Constitution that
22 precludes the Legislature and the Governor
23 from appointing a prosecutor, so we're
24 expecting that that issue will be resolved

1 this particular year.
2 I think the question that usually
3 follows that particular question is, so what
4 are we doing right now? How are we handling
5 cases? What about the criminal cases that
6 we're actively involved in?
7 So as I mentioned, the issue here is
8 independent authority, right? And the crux
9 of the issue is really do we need the consent
10 of the county DAs. Our position is that we
11 don't. However, as a safeguard and a
12 preventative measure, we have sought the
13 consent of the county DAs on all the criminal
14 cases where we are involved.
15 I think it's important to note we have
16 never prosecuted a case over the objection of
17 any single county DA. We work
18 collaboratively with them. We enjoy a very
19 cooperative relationship. And irrespective
20 of the outcome of this case, we will continue
21 to make sure that we're removing bad actors
22 from the workforce.
23 ASSEMBLYWOMAN GUNTHER: And what about
24 like -- if the communication with parents is

1 unchanged, as far as the Justice Center goes,
2 on changes in any policy or procedure?
3 There's a good line of communication?
4 EXECUTIVE DIRECTOR MIRANDA: Sure. So
5 communication, engagement, quite frankly,
6 transparency, has been a priority since I
7 arrived here three years ago. I'm very happy
8 to share that last year we launched a series
9 of regional conferences. We did one
10 conference in every single region, so there
11 were five last year.
12 This was a perfect opportunity for
13 family members, provider associations, and
14 smaller nonprofits to come and speak with
15 executive staff of the agency, to receive
16 updates, to get more information, to answer
17 questions. And then in the afternoon we had
18 sessions that were specifically focused on
19 some very unique parts of the agency. So
20 there was a topic of investigations, there
21 was also another panel discussion regarding
22 our criminal background check.
23 These were very well attended. We
24 plan on renewing that effort and launching

1 another series this year.
2 ASSEMBLYWOMAN GUNTHER: Well, I for
3 one have received less complaints about the
4 Justice Center, which is great. And, you
5 know, one of the largest employers in my
6 district are people that care for people with
7 disabilities. So thank you for what you've
8 done.
9 EXECUTIVE DIRECTOR MIRANDA: Thank
10 you.
11 CHAIRWOMAN KRUEGER: Thank you.
12 Senator Jim Seward.
13 SENATOR SEWARD: Thank you,
14 Madam Chair.
15 And Director Miranda, good to see you
16 again.
17 I know in the past -- I'm talking
18 about in the past -- a chronic complaint that
19 we had heard about the Justice Center was the
20 length of time of investigations. And I know
21 -- I think last year when you were before us
22 we had a discussion about that and you were
23 looking to shorten those times.
24 Can you give us an update in terms of

1 the length of time of investigations?
2 EXECUTIVE DIRECTOR MIRANDA: Sure.
3 So currently our average cycle time
4 for investigations is 69 days. Since we last
5 met here and spoke last year, we've taken on
6 several initiatives. We had the expansion of
7 one of our regions, we opened up an office in
8 White Plains in Westchester County. We do
9 that because we are constantly looking at the
10 data, trying to identify places in the state
11 where we need to deploy more resources. You
12 know, resources impact cycle times.
13 We work with the providers as well to
14 ensure that they are familiar with our
15 internal processes. You know, cycle time is
16 a priority, but it's also very nuanced and
17 complex. Cycle time is going to be impacted
18 by the type of case, the complexity of the
19 case -- sometimes we have multiple subjects,
20 sometimes we have multiple witnesses,
21 sometimes these investigations need to be
22 coordinated with labor unions or perhaps
23 counsel. We also rely on the provider or the
24 employer to supply us with the necessary

1 documents to review.
2 That said, cycle time is always a
3 priority for us. Recently we actually
4 expanded a program where we're now allocating
5 three business days to get additional
6 information for a provider. So in this pilot
7 program -- we've put about 2500 cases through
8 this pilot program, and what we've found is
9 that 65 percent of those cases have been
10 reclassified.
11 This is particularly important because
12 we do not have discretion as an agency when
13 it comes to a call that's coming in. If an
14 allegation of abuse and neglect comes in, we
15 are mandated to do an investigation, to reach
16 a conclusion, a substantiation or
17 unsubstantiation. We have to make a
18 classification based on that call.
19 There are instances where perhaps
20 there are gaps in the information, and so the
21 three business-day extension, for lack of a
22 better word, allows us to seek additional
23 information oftentimes from the provider, so
24 that we can make a much more accurate

1 classification. This has had a tremendous
2 impact on cycle time because it allows us to
3 make sure that we're deploying resources for
4 the cases that need it most.
5 SENATOR SEWARD: Thank you for that
6 update.
7 There -- there continues to be some
8 concerns that the Justice Center has, shall
9 we say, a law enforcement approach to all
10 investigations regardless of the nature of
11 those investigations in the original
12 complaint. This can lead to fear and anger
13 among the provider staffs that are out there.
14 How do you respond to those
15 allegations, and what actions have been taken
16 to take care of that?
17 EXECUTIVE DIRECTOR MIRANDA: So that
18 was a concern that was articulated when I
19 arrived here at the agency, and I think we've
20 gone to great lengths to make sure that we're
21 dispelling that myth.
22 You know, first and foremost we have
23 199 members of our investigatory unit; only
24 25 of those are sworn police officers. But

1 we do understand that sometimes, you know,
2 the actions of one or two can color an
3 agency, and so we've been extremely committed
4 to making sure that we're providing training
5 for all of our investigators on forensic
6 interviewing, best practices, working with
7 disabled populations. And quite frankly,
8 also reminding our entire agency -- in
9 particular our investigators -- that an
10 investigation is a traumatic event, whether
11 you are a witness, whether you are a subject,
12 whether you are a victim on a particular
13 case, and making sure that we're using a
14 trauma-informed approach when speaking with
15 people. Very important.
16 Additionally, we record all of our
17 interviews at the agency so when there is a
18 concern with respect to the tone or the
19 conduct of an investigator, this provides us
20 with an opportunity to actually review the
21 recordings and make sure that the conduct is
22 on par with our expectations.
23 SENATOR SEWARD: I do like your
24 emphasis on -- in your testimony and your

1 answers, on prevention and working with
2 providers to avoid problems before they come
3 up.
4 EXECUTIVE DIRECTOR MIRANDA:
5 Absolutely.
6 SENATOR SEWARD: One quick final
7 question in terms of the applicants for
8 background checks that you do for the various
9 agencies. You're looking at 13,000
10 applicants, but only a very small number,
11 380, were disapproved.
12 How do you account for that, such a
13 small percentage, being disapproved?
14 EXECUTIVE DIRECTOR MIRANDA: So
15 actually our statistics for last year, we did
16 100,000 criminal background checks. And so
17 there was a small number that were not
18 approved for employment due to
19 criminal-history backgrounds. So our volume
20 is actually significantly higher.
21 The number -- the amount of people who
22 were not approved, you know, this is based on
23 the criminal history and an assessment that's
24 done during the criminal background check

1 process.
2 SENATOR SEWARD: Do you have a -- any
3 speculation why there's such a small number?
4 Were those -- those maybe don't apply if they
5 have a --
6 EXECUTIVE DIRECTOR MIRANDA:
7 Thankfully, mm-hmm.
8 SENATOR SEWARD: Yeah. Thank you.
9 EXECUTIVE DIRECTOR MIRANDA: Sure.
10 CHAIRWOMAN KRUEGER: Thank you.
11 Assembly? No?
12 We're done. Thank you very much.
13 Appreciate it.
14 EXECUTIVE DIRECTOR MIRANDA: Thank
15 you.
16 CHAIRWOMAN KRUEGER: {Mic off.} I
17 have to leave for a meeting, but my very
18 capable cochair will be here in the interim.
19 CHAIRWOMAN WEINSTEIN: Thank you.
20 So now we begin the portion of the
21 hearing for the nongovernmental witnesses.
22 And just a reminder, the witnesses have up to
23 five minutes to present their testimony. As
24 you were forewarned in the beginning, it

1 would be best, especially since we've
2 received your testimony in advance, and it
3 has been circulated to all the members, to
4 try and summarize and not read word for word;
5 you end up not getting through it.
6 And just a reminder to members, any
7 members with a question are limited to three
8 minutes for question and answer.
9 So now we have New York Association of
10 Psychiatric Rehabilitation Services, Harvey
11 Rosenthal, executive director.
12 MR. ROSENTHAL: Good afternoon. Thank
13 you to the chairs and members of the
14 committee for your long-time partnership,
15 thoughtful oversight, and support of the
16 thousands of people with serious mental
17 illnesses and the providers that we support
18 at NYAPRS.
19 This is my 25th annual budget
20 testimony, having begun in 1995. And I
21 actually began my work in the field working
22 at the State Psych Center here in Albany in
23 1977. And at that time, a diagnosis of
24 mental illness was a life sentence; severe

1 functional limitations and frequent illness
2 and relapses were considered the norm.
3 Medication, hospitalization and community
4 institutions were the only major treatment
5 options, and people were rarely, were rarely
6 considered capable of good judgment.
7 Since the '80s we've all worked
8 together -- the providers, the consumers, and
9 government officials -- to raise the bar for
10 what's possible for people with mental
11 illnesses and what should be required from
12 our provider system. State mental health
13 policy is a very personal issue for me, my
14 community. I have a mental illness, and many
15 of the people who work in my office do, and
16 agency.
17 The lens through which we view the
18 budget has been based on the view that
19 everyone can recover, everyone can take on
20 responsibility, everyone can deserve the
21 dignity of an independent life in the
22 community and stable housing, employment, and
23 culturally good supports. That's the lens
24 that I'm going to offer this testimony.

1 The first issue I'm going to talk
2 about is the community -- funding for the
3 community services and the workforce. It's
4 important to distinguish that the money
5 that's been made available that you've heard
6 about, which is the 2 percent, is only for
7 the workforce and only for the workforce that
8 works for agencies that are funded by OASAS,
9 OMH, and OPWDD. So we're not talking about
10 the thing we've looked at, the COLA that's
11 been denied for over a decade. We are
12 talking now about across-the-board increases
13 for the agencies as well as the workforce.
14 Because those agencies are in a state of
15 crisis that you'll hear a lot more about.
16 Our group, which is the statewide
17 #3for#5 campaign, is calling for a 3 percent
18 increase across the board for each of the
19 next five years. And you'll hear that this
20 coalition is made up of an unprecedented
21 coalition of nonprofits across the human
22 service spectrum.
23 When it comes to Medicaid, we're quite
24 anxious about what we're going to hear in

1 Medicaid. We're worried about cuts. We're
2 grateful that we haven't been cut, as other
3 sectors were, by the 1 percent, and we're
4 looking for those kind of protections in the
5 coming budget. Since so much of the work
6 relies on the MRT, we want the state to
7 ensure there is significant representation
8 from the mental health community, consumers
9 and providers, and to allow for the active
10 level of participation I had in the past as a
11 member of the MRT.
12 Stable housing with individual
13 supports is fundamental to promote the
14 health, safety and dignity of people in
15 recovery. We're grateful that there's a
16 20 million add in this budget, and 60 million
17 for capital funds. More is needed. You'll
18 hear more about that.
19 There's a line in the budget, in
20 the OMH budget, that talks about increasing
21 the capacity in emergency departments. But
22 all it does is increase one more day of
23 reimbursement. It misses the point. People
24 are waiting in emergency rooms -- I visit

1 them, I see that -- for days, waiting for an
2 assessment. There is simply not enough staff
3 and facility, and we need to do more about
4 that than increase reimbursement by one day.
5 This budget increases -- permits, for
6 the first time ever, the use of Medicaid in
7 institutional settings. The IMD exclusion
8 that has set the tone for that has prevented
9 states from using Medicaid to expand
10 institutions. This budget takes a step that
11 we're very concerned about that will allow
12 Medicaid to provide services in an inpatient
13 setting.
14 You heard about the adult home
15 residents and the need for more services for
16 them. Over the last I think it's seven
17 years, only one in five of adult home
18 residents with psych disabilities who were
19 supposed to leave have left. The state needs
20 to do a lot more. We want to work with them
21 on that.
22 In terms of criminal justice
23 reforms -- I'll end with that -- there are
24 three parts. Crisis intervention teams --

1 Senator Carlucci has been terrific on that.
2 We've had several millions of dollars where
3 police are trained and supported not to
4 arrest or harm people and keep them out of
5 the criminal justice system.
6 We're very focused on diversion;
7 Mrs. Gunther has been great in funding an
8 alternative program in Westchester County
9 that helps keep people out of prison and
10 jail.
11 We want the passage of the HALT Bill
12 that will ban solitary confinement of people
13 with mental illnesses and limit it for other
14 populations. And I will stop there.
15 CHAIRWOMAN WEINSTEIN: Thank you.
16 Questions?
17 ASSEMBLYWOMAN GUNTHER: I think you
18 covered everything. And I know I'll see you
19 in my office if --
20 MR. ROSENTHAL: Okay, I'll be there.
21 CHAIRWOMAN WEINSTEIN: Thank you.
22 Next, Mental Health Association in
23 New York State, Glenn Liebman, CEO.
24 MR. LIEBMAN: Good afternoon. I want

1 to thank the Ways and Means Committee and the
2 Senate Finance Committee as well as our
3 chairs, our terrific chairs of -- you know,
4 both Assemblywoman Gunther and
5 Senator Carlucci have been outstanding
6 supporters of the Mental Health Association
7 and support for mental health services.
8 So really today is about two budget
9 narratives. The first one -- and Harvey did
10 a great job of describing -- considering this
11 economic climate, this actually was a pretty
12 good budget, relatively. Good credit goes to
13 Governor Cuomo and Commissioner Sullivan in
14 reflecting a budget with no major cuts to
15 mental health services. We were protected
16 from the first round of Medicaid cuts and
17 actually added funding for housing as well as
18 keeping the commitment to the direct-care
19 workforce.
20 But there's also Narrative No. 2. And
21 you all talked about it today with great
22 passion, and I heard this. This is not only
23 about New York, this is the country. We are
24 in a mental health crisis. And it's great

1 that the budget's been positive, but we are
2 in a crisis.
3 And I've been doing this for 17 years
4 and I rarely have said the word "crisis," but
5 this is what we are doing. Individuals and
6 families are suffering. We heard the stories
7 about six-month waiting lists for services,
8 two-year waiting lists for housing,
9 overworked and underpaid workforce, exploding
10 rates of anxiety, depression, and suicide
11 attempts among young people, shortage of
12 mental health professionals, suicidality
13 among veterans and discrete populations,
14 people not getting Medicaid for months as
15 they're released from jail and prison while
16 spending all this time -- so much of their
17 time, unfortunately -- in solitary
18 confinement as well.
19 So how do we respond to this crisis?
20 There are no simple answers. And frankly,
21 New York is better that virtually any other
22 state. But we're not here to blame or to
23 point fingers. We're here for fixes. And
24 yes, these fixes cost money. And yes, we're

1 in a budget of fiscal constraint. But the
2 reality for us in mental health is that it
3 doesn't matter if it's a good budget or a bad
4 budget, we always only get a small slice of
5 the pie.
6 The reality is we're not a small slice
7 of the pie. We actually comprise almost the
8 entire pie. One in five people in the
9 United States has a serious mental health
10 issue. Almost half of all Americans will
11 have a diagnosed mental health issue in their
12 lifetime. I doubt there is anyone in this
13 room, or anywhere that we know of, that has
14 not been either directly or indirectly
15 impacted by mental health and mental illness,
16 whether as a family member, themselves, or as
17 a close friend.
18 In the context of our following
19 recommendations, we urge you to keep this in
20 mind, the importance of what we're advocating
21 for, and the significance of financial
22 support for our stated goals.
23 So I have here -- obviously I'm not
24 going to read it -- I have about 26 different

1 recommendations. And I'm going to focus
2 really on two things in particular. And
3 that's not to minimize all the other 24 other
4 things, because they're all equally as
5 significant. But what I'm going to focus on
6 right now -- and Harvey talked about it as
7 well -- is the #3for#5 campaign.
8 So this is an unprecedented move
9 whereby the entire human service sector
10 non-for-profit community is speaking with one
11 voice -- and you're going to hear from other
12 people today too. Mental health,
13 developmental disabilities, addiction
14 disorders, aging, child welfare, domestic
15 violence, we're all speaking with one voice.
16 We're all advocating for a 3 percent increase
17 in funding for the next five years. So
18 that's where the campaign is, the number 3,
19 "for" spelled out, f-o-r, 5. Three for five.
20 We've lost over a billion dollars in
21 the last decade by COLAs not being part of
22 the human service sector. We were supposed
23 to get a COLA every year for the last
24 11 years. It's been carved out every year,

1 unfortunately. We've lost -- our entire
2 sector has lost over a billion dollars.
3 Think about how these nonprofits provide
4 service and support for those in greatest
5 need, and think of how different our lives
6 would be if we had that funding.
7 We are the safety net for these
8 people. And for those of us in mental
9 health, what the safety net means is housing,
10 care management, respite, clinic services,
11 medication management, peer support,
12 employment, education and much more.
13 We get two questions a lot in this
14 campaign: Why this year, when we know this
15 is a difficult budget year? The bottom line
16 is, we don't pick a year. This is a fiscal
17 crisis. We're in a financial crisis. We
18 can't say that, jeez, we should start the
19 #3for#5 campaign next year or the year after.
20 We are in a crisis. Everybody here today is
21 going to talk about this, because this is the
22 reality.
23 And we do appreciate the 2 percent
24 across-the-board funding cut -- I mean,

1 funding increase for the direct care
2 workforce. We do appreciate that very much.
3 But the bottom line is we need more and our
4 entire sector needs more.
5 And the other thing is, we're the
6 taxpayers' best friends. We are economic
7 drivers in the community, but we're also
8 taxpayers' best friends. When you're talking
9 about things like -- what are we talking
10 about here? With DSRIP and Medicaid managed
11 care and everything else, it's all dedicated
12 to keeping people out of expensive settings
13 and in the communities. That's what we do in
14 the nonprofit sector every day. We are doing
15 really great work in the community, and we're
16 saving people money as well.
17 So we hope that as we move forward,
18 that that $170 million we're asking for will
19 be added in the budget.
20 Do I have time for one more quick
21 thing? Or I'm being --
22 CHAIRWOMAN WEINSTEIN: Just finish up
23 that -- finish up your last thought.
24 MR. LIEBMAN: Okay. Mental health

1 education in schools, really significant. We
2 really appreciate the support of our chairs
3 in this area. And we have a handout in the
4 back of the report about the work we're doing
5 in schools and communities around
6 mental health and our resource center.
7 And we appreciate Assemblywoman
8 Gunther putting us -- initial support, as
9 well as now the Governor in the last two
10 years.
11 And we also appreciate --
12 Senator Carlucci's just introduced a bill
13 last week around teacher training, and that's
14 the next step forward in terms of teacher
15 education -- I mean, around mental health
16 education in schools.
17 So thank you very much.
18 CHAIRWOMAN WEINSTEIN: Thank you.
19 Senator Carlucci.
20 SENATOR CARLUCCI: Thank you, Chair.
21 Thank you, Glenn.
22 I wanted to ask you about -- you
23 touched on mental health first aid and the
24 importance of that. So I was going to ask

1 you about that. But I also wanted to ask,
2 because you didn't get to it, about crisis
3 intervention teams.
4 MR. LIEBMAN: Yes.
5 SENATOR CARLUCCI: I know the Mental
6 Health Association in New York has been
7 really pushing that initiative. Could you
8 tell us why that's important and why we need
9 to put it in the budget?
10 MR. LIEBMAN: Sure. And again, we
11 appreciate your leadership in that area,
12 because it does mean a lot. And you're going
13 to hear, you know, NYAPRS is talking about
14 it, and you're going to hear from NAMI as
15 well about how important it is to a lot of
16 us.
17 Basically, crisis intervention teams
18 are a best practice that brings together law
19 enforcement and individuals and their
20 families who are in crisis, in a mental
21 health crisis, to plan, be planful in the
22 process -- what should law enforcement look
23 for, what should they pay attention to when
24 somebody's in a current crisis, how do we

1 minimize that crisis and make sure that, you
2 know, we don't have those terrible outcomes
3 that we so often have.
4 And so we're very appreciative of this
5 funding. It is a best practice, and it's
6 going on in counties around the state now.
7 And this is relatively new, this is only in
8 the last five years, because for years New
9 York was behind the 8-ball on this, and now,
10 you know, with your leadership and the other
11 leadership, we've really been able to really
12 implement some really strong work around CIT,
13 which is really a positive for everybody in
14 our community.
15 SENATOR CARLUCCI: Great. And what do
16 you think we need in terms of funding in the
17 state to meet the needs to have more law
18 enforcement trained in crisis intervention?
19 MR. LIEBMAN: Well, you know, I'd have
20 to do an environmental scan to find out how
21 many counties already have CIT and how many
22 counties need to have CIT. Because everybody
23 wants it, and I think it would be appropriate
24 for everywhere. So I don't know exact

1 numbers, but I think that's appropriate.
2 And the other thing is -- and you know
3 this well -- is that Mental Health First Aid,
4 specifically for counties that have CIT -- in
5 a lot of counties, as we know, law
6 enforcement, it's hard for them to take a
7 35-hour training. Mental Health First Aid
8 has been the perfect backdrop for those
9 individuals who are interested in finding out
10 more about law enforcement, how to work
11 mental health and law enforcement. And
12 Mental Health First Aid has been that
13 ancillary piece that's been very helpful.
14 SENATOR CARLUCCI: And with Mental
15 Health First Aid, you know, it's been great.
16 I talk to my children's preschool teachers,
17 they've taken the course, they've signed up
18 for the eight-hour course.
19 Can you tell us how many people have
20 been trained on Mental Health First Aid in
21 New York State? Do you have that number?
22 MR. LIEBMAN: I don't have it for
23 New York State specifically. I do have it
24 for the country as a whole: 2.5 million

1 people have been trained in Mental Health
2 First Aid across the country. And that's
3 whether it's preschool teachers, you know,
4 law enforcement, librarians -- every sector
5 has been taught in Mental Health First Aid.
6 And I know that we in New York State
7 have done -- again, over the last several
8 years we've gotten the funding to be able to
9 go out there, and our members are certainly
10 doing it around the state, and I know there
11 have been hundreds of trainings that are
12 going on consistently around the state.
13 SENATOR CARLUCCI: Thank you, Glenn.
14 Thank you, Chair.
15 MR. LIEBMAN: Thank you.
16 CHAIRWOMAN WEINSTEIN: Thank you.
17 Thank you for the work you do on this
18 issue.
19 MR. LIEBMAN: Thank you.
20 CHAIRWOMAN WEINSTEIN: Next we have
21 the National Alliance on Mental Illness-
22 New York State, Ariel Coffman, president.
23 MS. BURCH: Good afternoon. I'm
24 actually Wendy Burch. I'm the executive

1 director for NAMI-NYS.
2 Our organization represents thousands
3 of New Yorkers living with a mental health
4 condition, as well as their family members.
5 I appreciate the opportunity to present
6 testimony today, and thank you for allowing
7 me to do so.
8 We have submitted our written
9 testimony to you, so of course in the
10 interests of time, I'd just like to take a
11 moment to highlight some of the needs we see
12 in the course of our work at NAMI.
13 First we want to ensure that those who
14 need it have access to care and services. We
15 recognize that people living with mental
16 health issues, when provided with appropriate
17 services in a timely manner, can live healthy
18 and productive lives.
19 Having the necessary supports in place
20 can prevent long-term hospitalization,
21 homelessness, incarceration, and the risk of
22 them taking their own lives.
23 This is the reason that NAMI-NYS has
24 joined the #3for#5 campaign. Access to care

1 begins by having human services agencies who
2 have the ability to run their programs in a
3 way that allows them to provide the
4 continuity of care that is critical to
5 recovery. It is significant and speaks to
6 the seriousness of the situation that so many
7 providers and supporters across human
8 services have come together to support and
9 promote this campaign.
10 We urge you to lend your support as
11 well and institute the 3 percent increase in
12 funding for nonprofits in the human services
13 sector every year for the next five years.
14 NAMI-NYS was pleased to see that the
15 Governor's budget reflects the importance of
16 adequate community-based mental health
17 housing by including an additional
18 $20 million for existing residential
19 programs. However, this investment still
20 falls short of what is needed to address the
21 quarter-century of flat funding to nonprofit
22 mental health housing programs.
23 We urge the Legislature to close the
24 gap in funding these vital programs.

1 Recovery is only possible when a person first
2 has a safe and stable place to live.
3 Along with residential and treatment
4 services, crisis services are also
5 desperately needed. NAMI-NYS believes that
6 no one should have to travel more than an
7 hour to access psychiatric emergency crisis
8 services. Unfortunately, this goal is
9 unattainable for far too many New Yorkers.
10 We need investments to expand both mobile
11 crisis services such as assertive community
12 treatment teams and mobile intervention
13 teams, as well as stationary options such as
14 crisis stabilization centers and respite
15 centers.
16 We would like to commend the Governor
17 and the Legislature for their support in
18 several areas. The first is in the area of
19 parity for mental health. The establishment
20 of an ombudsman to oversee parity in the
21 CHAMP program, and now the Behavioral Health
22 Parity Compliance Fund, will help to ensure
23 that mental health issues are treated fairly
24 by insurance companies.

1 We would also like to commend the
2 Legislature for its commitment to improving
3 the criminal justice-mental illness
4 interface, particularly the investment in
5 crisis intervention teams. We hope to see an
6 increasing emphasis on diversion initiatives,
7 including the commitment to ensuring that
8 psychiatric services exist, and are
9 accessible, in which to divert individuals
10 from incarceration to recovery.
11 Finally, as a former member of the
12 armed services, I was pleased to see an
13 investment of the $1 million for services and
14 expenses related to suicide prevention
15 efforts for veterans, law enforcement and
16 first responders. The defenders and
17 protectors of our nation deserve the support
18 of the community, especially in times of
19 personal struggle.
20 Thank you for the opportunity to
21 provide input to you today. I know you will
22 continue to invest in initiatives that
23 support those working towards recovery so
24 that they can truly be a part of the

1 community and lead healthy and productive
2 lives. Thank you.
3 CHAIRWOMAN WEINSTEIN: Thank you for
4 your concise testimony. As you noted, we do
5 have the full testimony and it was circulated
6 to all the members.
7 I don't believe there are any
8 questions. Thank you for being here today.
9 MS. BURCH: Thank you.
10 CHAIRWOMAN WEINSTEIN: Next we have
11 New York State Conference of Local Mental
12 Hygiene Directors, Kelly Hansen, executive
13 director.
14 MS. HANSEN: Good afternoon. My name
15 is Kelly Hansen. I'm the executive director
16 of the New York State Conference of Local
17 Mental Hygiene Directors, and I appreciate
18 the opportunity to present testimony to you
19 today on the Governor's Executive Budget.
20 The conference represents the
21 directors of community services and county
22 mental health commissioners in each of the
23 57 counties and the Department of Mental
24 Hygiene for the City of New York.

1 Given the five minutes -- you have my
2 full testimony, but I want to spend my time
3 on two specific pieces. One is to be able to
4 report to you how the funding was spent that
5 the conference had advocated for and you
6 provided for jail-based substance use
7 disorder treatment and transition services.
8 It's on page 4 of your testimony.
9 And also I wanted to provide a
10 clarification around the discussions that
11 have occurred earlier around jail-based
12 competency restoration and also the shift to
13 the 100 percent county cost of state
14 psychiatric center treatment for competency
15 restoration.
16 So the conference, in partnership with
17 our partners in the New York State Sheriffs'
18 Association and also the New York State
19 Association of Counties, two years ago were
20 successful, with your help, in securing
21 $3.75 million to be able to provide
22 jail-based substance use disorder treatment.
23 And the reason that we were advocating for
24 this funding is because while the state had

1 developed a number of community services, we
2 know that our folks traditionally have
3 significant interaction with the criminal
4 justice system, and they would be brought
5 into jail and we had no funding to be able to
6 provide services to them.
7 So last year's budget included the
8 3.75, the Governor continued that, and as
9 Chairwoman Rosenthal had indicated --
10 CHAIRWOMAN WEINSTEIN: Why don't you
11 hold on for a minute. Let's try and -- I'm
12 not sure if it's your mic or the -- maybe try
13 shifting --
14 MS. HANSEN: Switch? Okay.
15 CHAIRWOMAN WEINSTEIN: Yeah. I'm not
16 sure if it's the microphone or the speaker
17 feedback we're getting.
18 MS. HANSEN: I have a one-out-of-three
19 chance to get this -- is this better? So far
20 so good? All right, thank you. And thank
21 you for stopping the clock, I appreciate it.
22 So as I was mentioning, there was
23 3.75 million in the budget. Our original ask
24 was for 12.8, to be able to provide funding

1 for each of the counties outside of New York
2 City. New York City has a well-established
3 program.
4 We got 3.75. So the result of that
5 was roughly $60,000 to each county to be able
6 to provide those services. One of the pieces
7 is that Herkimer County, with 58 people in
8 their jail, got $60,000. Nassau County, with
9 over a thousand individuals in their jail,
10 got $60,000.
11 However, I'm pleased to report that we
12 had done a very in-depth survey of our county
13 mental health commissioners over the summer
14 and asked, what specifically did you use this
15 funding for, and did you create a new service
16 or did you enhance an existing service?
17 So a few of the numbers I just want to
18 point out to you is that 20 jails were able
19 to create individual and group counseling
20 services. Fourteen jails created peer
21 services, which are so important. And
22 15 jails were able to put in place transition
23 and reentry services.
24 So we have revised our budget ask

1 based on what we anticipate may be the impact
2 of bail reform. We don't have a visual into
3 what the numbers will change, but we do know
4 that there will still be a need in county
5 jails to be able to offer treatment.
6 So in addition to the 3.75, we're
7 asking for another 3.25 to bring our total to
8 $7 million. That's our ask.
9 Also, as part of last year's budget,
10 there was another million added to pay for
11 the cost of medications only in the jail.
12 That, as you've heard, was not
13 reappropriated, and we're hoping that that
14 funding will be forthcoming.
15 The other piece I just want to quickly
16 talk about is the provision for authorizing
17 counties to do jail-based competency
18 restoration. I can tell you that based on
19 what I hear from my members, who are all
20 clinicians, I don't know any who think that
21 doing restoration in a jail is a good place
22 to provide mental health treatment.
23 There's also significant issues with
24 being able to not provide medication over

1 objection, training staff. We just don't
2 think that this is a good appropriate place
3 to provide restoration, yet every year it
4 turns up in the budget. So we wanted to
5 point that out.
6 The other piece that we're very
7 concerned about, and we will be coming to you
8 to discuss further, is an assumption in the
9 budget that shifts the cost of competency
10 restoration for someone who is in the care
11 and the custody of the state commissioner of
12 the Office of Mental Health, receiving
13 treatment in a state-operated psychiatric
14 center, to be returned to competency prior to
15 going back to face a criminal justice
16 procedure because they have been restored
17 such that they understand the charges against
18 them and can advocate on their own behalf.
19 In current years, the state has
20 charged the county 50 percent of a per-diem
21 rate for 730 competency restoration. This
22 would do a shift so now the counties would
23 pay 100 percent of the daily cost per person
24 for competency restoration. Outside of

1 New York State, we're looking at 12 million.
2 I can tell you that there's no
3 planning that a county could do for the cost
4 of restoration. You could go four years
5 without a 730, and then you've got six 730s
6 in one year and it costs you hundreds of
7 thousands of dollars -- or millions, in some
8 counties. So we -- and this money goes into
9 the General Fund. I think that's important
10 to point out.
11 So thank you very much for your time,
12 and we'll be visiting you later.
13 CHAIRWOMAN WEINSTEIN: I'm going to
14 ask a question about what you just said. So
15 you heard the commissioner respond to
16 questions about this topic of the local jail
17 restoration. And I guess what I'm hearing
18 from you is you don't agree.
19 She was saying that people could be
20 treated in the local jail, which would be
21 reasonable to the county than having them
22 treated in a hospital setting. But you seem
23 to say both that that's not an appropriate
24 setting and that the costs are greater than

1 what she's saying.
2 MS. HANSEN: You are correct,
3 Chairwoman. I think there was a lot of
4 confusion in the discussion between
5 jail-based competency restoration and
6 allowing counties to do jail-based -- keep in
7 mind, this is an individual who's been
8 charged with a crime, generally felony level,
9 who's been evaluated and deemed incompetent
10 to go forward in the judicial proceedings
11 because they have a mental illness and have
12 been deemed to not understand the charges
13 against them and not able to aid in their own
14 defense.
15 So under law, that individual is then
16 transferred into the care and custody of the
17 commissioner of the Office of Mental Health,
18 and they are then treated at a state
19 psychiatric forensic center -- Kirby, some of
20 the others -- until they are restored to
21 competency, and then they would come back.
22 So the first piece is the jail-based
23 restoration, which is -- I don't agree that
24 it's a fiscal benefit to the counties. And

1 from the clinical standpoint, my members
2 would tell you that they don't agree that the
3 jail is a good place to provide mental health
4 treatment.
5 The other piece is on what has
6 currently gone forward with the cost of the
7 730 -- same thing, 730 Criminal Procedure
8 Law -- for the competency restorations, where
9 the counties have traditionally been charged
10 50 percent of the per-diem cost for a 730 --
11 all of which that money goes into the General
12 Fund -- and now that would be shifted to the
13 counties paying 100 percent of the cost.
14 New York City apparently started
15 paying 100 percent of the cost last year, and
16 it's millions of dollars. And we're trying
17 to find the justification as to why this is a
18 county cost as well.
19 CHAIRWOMAN WEINSTEIN: Thank you.
20 Senator Carlucci.
21 SENATOR CARLUCCI: Thank you, Director
22 Hansen. And thanks for coming to our
23 committee and giving us an overview, to the
24 Senate, of what some of the priorities are

1 and what you're working on.
2 And to follow up on the jail-based
3 restoration program, the shift is something
4 that we're all very concerned about in that
5 cost, and what it just means to the locality.
6 And do you have an idea from your estimate of
7 what -- for the local mental hygiene
8 directors, what that cost shift will be for
9 the rest of the State of New York outside of
10 New York City?
11 MS. HANSEN: We're told that, fully
12 annualized, about $12 million.
13 SENATOR CARLUCCI: Okay, $12 million.
14 So it's right now -- just so I understand it
15 correctly, it's probably about $24 million
16 annually, and the county gets reimbursed half
17 of that?
18 MS. HANSEN: No, it's -- we reimburse
19 6 million. Rest of state, the cost is
20 12 million. That would be the shift to
21 100 percent for the county. And New York
22 City is separate.
23 SENATOR CARLUCCI: Okay. So right
24 now, under your calculation, it would be --

1 if it stayed the same as last year, on
2 average, it would be about a $6 million
3 increase to the counties.
4 MS. HANSEN: Correct.
5 SENATOR CARLUCCI: Okay. Thank you.
6 MS. HANSEN: That's my estimate, I
7 guess.
8 SENATOR CARLUCCI: Okay. And last
9 year the Governor did put in $850,000 to
10 incentivize counties to take on this
11 challenge. And could you just elaborate a
12 little bit more how -- you did make the
13 statement that you didn't think that that's
14 an appropriate place to get treatment.
15 Could you just tell us about your
16 reasoning?
17 MS. HANSEN: Certainly. Thank you.
18 And, you know, based on what I --
19 my -- our commissioners' discussions, you
20 know, I think -- if someone is deemed
21 incompetent, they have a severe mental
22 illness, a pretty high diagnosis. And I
23 don't know how much time you've spent in
24 jails lately; I spent a lot with our SUD

1 project. And to put staffing in a jail --
2 you need clinical staff, not COs. Clinical
3 staff. And it's not a therapeutic place by
4 any stretch of the imagination.
5 The other piece is for a number of
6 individuals, being started on a medication
7 regimen is extremely important to starting to
8 treat a serious mental illness. The jails
9 cannot medicate over objection without going
10 to court, and that takes away one of the very
11 significant tools that would need to be in
12 place in order to do jail-based restoration
13 if any county wanted to do that.
14 I know other states have done it. I
15 don't see a lot of uptake from our members
16 that would think that this is a good
17 placement. And I also don't think that, by
18 having the counties pay 100 percent of the
19 cost, that that provides any change in the
20 therapeutic discussion or that all of a
21 sudden people will want to do jail-based
22 restoration.
23 SENATOR CARLUCCI: Okay, thank you.
24 MS. HANSEN: Thank you.

1 CHAIRWOMAN WEINSTEIN: Thank you.
2 Assemblywoman Rosenthal.
3 ASSEMBLYWOMAN ROSENTHAL: Thank you.
4 Hi, good to see you.
5 MS. HANSEN: Great seeing you.
6 ASSEMBLYWOMAN ROSENTHAL: So last year
7 we worked closely together, and left on the
8 floor was my medication-assisted treatment
9 bill, which I hope to get to pass this year.
10 How much money do you really think
11 would be necessary in order to accomplish
12 what we're trying to do?
13 MS. HANSEN: There's a couple of
14 different factors. Number one is, again, we
15 don't have a visual yet into what the jail
16 census will be. And keep in mind that
17 someone's jail stay is generally anywhere
18 from 14 to maybe 20 to, outliers, 40 days.
19 So we're working with folks in a relatively
20 short timeline.
21 But the N, the number of individuals
22 in jail, is in part what drives what we put
23 together as a fiscal assumption.
24 For the medication-assisted treatment

1 bill, we issued and shared with you and
2 others a fiscal impact that took a very
3 conservative approach and said that at any
4 given time in the county jail system outside
5 of New York City, individuals -- you'd have
6 50 individuals on Vivitrol, 50 individuals on
7 methadone, 50 individuals on Suboxone, and
8 50 individuals on Sublocade.
9 And as you know, the cost of these
10 medications is significant. And in addition
11 to the cost is having the waiver prescribers,
12 the clinical piece around it. And you
13 mentioned, Assemblywoman, that
14 medication-assisted treatment is the
15 medication and the clinical piece together,
16 it's all together. I sometimes think that
17 gets lost in the discussion.
18 So our concern was the cost, with how
19 do you build these programs? And what we're
20 saying is continue to fund our counties to be
21 able to develop the counseling, the
22 behavioral health services that are needed in
23 order to overlay a medication-assisted
24 treatment program. because we're not there

1 yet. We've made great progress, with your
2 support and funding, but we have more to go.
3 So that was what our position was in
4 terms of let's continue building services in
5 the jails so we can help people in those 14
6 to 22 days, and have transition services in
7 place for a good, solid reentry into the
8 community.
9 ASSEMBLYWOMAN ROSENTHAL: Are the --
10 the supply of Vivitrol, is that part of an
11 agreement with the company that makes
12 Vivitrol?
13 MS. HANSEN: I don't know. I mean, I
14 think that's more a sheriff discussion. I
15 think it was the first one that was, you
16 know, available on the market. It's
17 injectable, and certainly that's a
18 consideration as well. I mean, Sublocade is
19 injectable now too, as things have changed.
20 ASSEMBLYWOMAN ROSENTHAL: Right.
21 Right. Right.
22 But would you call it a good
23 investment? You know, we're going to try to
24 unearth that money. You call it a good

1 investment toward getting people back on the
2 right path.
3 MS. HANSEN: I think any money to the
4 county mental health commissioners that would
5 allow us to expand treatment and transition
6 services in the jails is a good idea for all
7 individuals.
8 ASSEMBLYWOMAN ROSENTHAL: Thank you.
9 CHAIRWOMAN WEINSTEIN: Thank you.
10 Thank you for being here.
11 MS. HANSEN: Thank you.
12 CHAIRWOMAN WEINSTEIN: Next, Substance
13 Abuse Providers in Schools, Kevin Allen,
14 chair, Local 372. And Donna Tilghman,
15 secretary. Thank you.
16 MR. ALLEN: Good afternoon. To the
17 chairperson, to the distinguished members,
18 how's everyone? My name is Kevin Allen.
19 Along with Donna Tilghman, we represent
20 275 substance abuse or prevention and
21 intervention specialists of the New York City
22 Department of Education, Local 372 with
23 DC 37.
24 You have the information in front of

1 you, but I just want to make it personal so
2 it would resonate. The SAPIS is the only
3 person in the school that works a 12-month
4 year. As opposed to guidance counselors, as
5 opposed to various teachers that have grades
6 K-12, SAPIS have all grades, kindergarten
7 through 12th grade. They also deal with
8 students from A to Z.
9 They also are the only people in the
10 building that deal with an evidence-based
11 curriculum that we teach. And it's across
12 the board, all over New York City. Life
13 skills, Second Step, Too Good For Violence,
14 Too Good For Drugs, are just examples of
15 evidence-based curriculum that OASAS has
16 okayed, along with the Department of
17 Education, for us to show fidelity throughout
18 no matter what borough, what school you go
19 into, SAPIS will be teaching out of this
20 curriculum.
21 We are here asking for a joint
22 legislative appropriation of 2 million
23 plus -- 2 million from the Assembly,
24 2 million from the Senate.

1 As any successful corporation, any
2 successful organization, there's two things
3 that are always important to them. One is
4 scalability, and the other one is
5 scalability. To sustain and to build. And
6 so we're at the point where we are glad that
7 we have dedicated SAPIS, but we want to be
8 able to keep who we have and to be able to
9 build on their reputation and build on their
10 success that they've already built.
11 They do classroom presentations, they
12 do positive alternatives, they meet with
13 parents, they meet with communities. Because
14 of the new vaping, we are doing vaping demon
15 -- we're talking about vaping from another
16 perspective where we already have established
17 DVDs on that and we're bringing more parental
18 and more community awareness to that.
19 As our commissioner had just come to
20 speak about, there is more than ever before a
21 direct correlation between substance abuse
22 and mental health. And we see that going
23 down from our high schools to our middle
24 schools and to our elementary students. And

1 what we want to do is give them as much
2 information, give them as much of a
3 foundation to be able to change the course of
4 a child's achievement from kindergarten to
5 the 12th grade.
6 We are excited about that, and we're
7 asking for the -- for both the Assembly and
8 the Senate to each contribute $2 million
9 towards SAPIS in this year's budget, for a
10 shared allocation of $4 million in funding.
11 All together, this would preserve and
12 create the equivalent to at least 48
13 full-time SAPIS positions, and the potential
14 to reach up to 24,000-plus students and their
15 families who would otherwise not have the
16 support that they need.
17 We just don't want to be driven on
18 data, but we want to be also driven on
19 results. And as we go into each and every
20 school, each and every school has several
21 things that are in common. They all have
22 their own culture, their own climate, and
23 their own community and language. And
24 because of all of these things, we see that

1 it's more necessary than ever before to bring
2 home the message of this.
3 One additional thing that a SAPIS does
4 that no one else has, the way that we do it
5 is that we have built our social-emotional
6 needs in these lessons. If there's
7 15 lessons and life skills curriculum, and if
8 there's 13 lessons and a Second Step,
9 85 percent of those lessons are based on
10 social-emotional. Which means that we want
11 to get to the root of the matter.
12 I thank you for listening, and if
13 there's any questions, please feel free to
14 ask.
15 CHAIRWOMAN WEINSTEIN: Senator Liu for
16 a question.
17 SENATOR LIU: Thank you, Madam Chair.
18 Not so much a question, I just wanted
19 to thank Mr. Allen and his colleague. They
20 are leaders at Local 372 who really are
21 instrumental. I mean, honestly, when we talk
22 about schools, we -- when we're thinking
23 about schools, we talk about teachers,
24 principals. We often forget the other staff

1 that rounds out the education and the care
2 for our kids.
3 So thank you and your members for all
4 the work that you do. And I certainly will
5 support this.
6 MR. ALLEN: Thank you, Senator.
7 CHAIRWOMAN WEINSTEIN: Assemblywoman
8 Rosenthal.
9 ASSEMBLYWOMAN ROSENTHAL: Hi.
10 I too would like to commend all the
11 good work that you do in schools. And the
12 Assembly for years have provided $2 million
13 in extra funding for you, which I hope this
14 year we can -- each house can provide
15 $2 million, that's my goal.
16 I wonder if you could just expand on
17 how, if you got this increased funding --
18 right now you have 270 people working in the
19 schools, right?
20 MR. ALLEN: Yes.
21 ASSEMBLYWOMAN ROSENTHAL: And how many
22 more could you get if we increased the
23 funding?
24 MR. ALLEN: We would go to at least 24

1 to 50 more additional people, 48 full-time.
2 Which means that if there's 1700 schools in
3 the New York City Department of Education, it
4 would be even that more that we'll be able to
5 get at any point.
6 And that means even with the point of
7 having a SAPIS collocated in different
8 schools, which we have in some situations, we
9 can fill that need more prevalent than is
10 happening.
11 ASSEMBLYWOMAN ROSENTHAL: I mean, one
12 of the key elements everyone talks about is
13 prevention, education and then, of course,
14 treatment and recovery. But if we don't do
15 the first two points, we're not -- you know,
16 we're going to keep going down a bad road.
17 So I think your work is essential.
18 And I know you have included vaping now,
19 because that is also --
20 MR. ALLEN: Yes, we have.
21 ASSEMBLYWOMAN ROSENTHAL: -- something
22 all the kids are doing, unfortunately, in
23 schools. But I think your model is great,
24 and continue to do the great work you do.

1 Thank you.
2 MR. ALLEN: And I thank you for your
3 support.
4 And we've seen, more than ever
5 before -- it seems that every other week
6 there's another vaping fatality. And we take
7 that to heart. And the information that
8 we're able to give each and every student,
9 which gives to each and every family, that
10 gives to each and every community, that gives
11 to each and every city, that's what we want
12 to circumvent, that type of thing.
13 Because we're talking about -- the new
14 word is the "C" word, contemporary issues.
15 These are issues that maybe 15 or 20 years
16 ago, we did not see as rampant as we see now
17 in our elementary, middle school and high
18 school students. So we want to be right on
19 the cutting edge in regards to this.
20 ASSEMBLYWOMAN ROSENTHAL: Okay. Thank
21 you.
22 MR. ALLEN: Thank you.
23 CHAIRWOMAN WEINSTEIN: Thank you for
24 being here. And again, thank you for the

1 work your members do in the city schools.
2 MR. ALLEN: Thank you, Chairperson.
3 CHAIRWOMAN WEINSTEIN: Next, Friends
4 of Recovery-New York: Angelia Smith-Wilson,
5 executive director; Allison Weingarten,
6 director of policy.
7 And if you're keeping score, after
8 this will be research for a Safer New York,
9 then Legal Action Center, then The Arc
10 New York.
11 MS. SMITH-WILSON: Good afternoon. I
12 am Angelia Smith-Wilson, the executive
13 director of Friends of Recovery-New York.
14 Friends of Recovery-New York is the only
15 statewide recovery organization in New York
16 State, and we represent the voice of
17 individuals and families living in recovery
18 from addiction, families who have lost a
19 family member, or people who have been
20 otherwise impacted from addiction. I myself
21 am a family member in recovery.
22 In New York State there are over
23 260,000 admissions annually. These
24 admissions make up crisis and noncrisis

1 admissions to treatment facilities. We know
2 that those folks that enter a treatment
3 facility will leave that treatment facility
4 and reenter their community. So it is
5 important that we keep at the front of any
6 discussions around addiction and addressing
7 the opioid crisis. When we talk about
8 treatment, we cannot miss talking about
9 recovery, because recovery wraps itself
10 around and supports people as they leave
11 treatment. It supports the treatment itself.
12 So fortunately since 2017,
13 recovery-oriented systems of care, which
14 include the development of recovery community
15 organizations, recovery community outreach
16 centers, recovery youth clubhouses, peer
17 engagement specialists, family support
18 navigators -- these services, combined, have
19 touched over 250,000 individuals, saving
20 lives to no doubt mitigate the overdose
21 crisis that we are currently in.
22 We respectfully ask you to further
23 continually consider recovery in your
24 discussions when you discuss being effective

1 at addressing the current opioid drug crisis,
2 as without adequate funding, as we have heard
3 today, as you have pointed out today,
4 treatment services will not be fully
5 supported if you are not supporting recovery
6 services. So more funding is needed.
7 We would ask that any proceeds coming
8 from the opioid settlement dollars -- which
9 we estimate could be as high as $1 billion --
10 to be directed to evidence-based prevention,
11 treatment and recovery services, as these
12 dollars in particular, $40 million of them,
13 are needed to further ensure that one
14 recovery community organization, one recovery
15 community outreach center, one recovery youth
16 clubhouse, two peer engagement specialists,
17 two family support navigators, can and will
18 be in every county throughout New York State.
19 So in addition, we are very much in
20 tune -- in light of the sign of the times in
21 increasing access to substances, we are very
22 concerned about our youth. So Allison will
23 talk about that point.
24 MS. WEINGARTEN: Thanks, Angelia.

1 And I would like to just say that I
2 work very closely with a group called Youth
3 Voices Matter in New York State, and they are
4 under the Friends of Recovery organization.
5 And there are currently three young people
6 employed in Western New York, New York City,
7 and the Capital Region, to go out and find
8 young people and support recovery.
9 And if we're talking about a continuum
10 of care, we like to say that prevention is
11 recovery, especially for young people. So
12 that we are providing these services so that
13 young people don't feel like they're alone.
14 So that is federally funded, and we
15 are definitely looking for your support,
16 especially over the next year, to try and get
17 that embedded in the state budget.
18 And I want to say that that program is
19 being recognized federally. Angelia attended
20 a conference last summer, a national
21 conference, and that New York State program
22 was getting that kind of credit. So we want
23 to definitely see that continue.
24 Thank you so much.

1 MS. SMITH-WILSON: Thank you.
2 CHAIRWOMAN WEINSTEIN: Thank you for
3 being here.
4 Senator Carlucci.
5 SENATOR CARLUCCI: Thank you, Chair.
6 And thank you both for being here
7 today. Director Smith-Wilson, Angelia, good
8 to see you again.
9 And I just want to thank you for your
10 commitment to our community. I know we have
11 a very strong group in Rockland and
12 Westchester Counties with Friends of
13 Recovery, and it's been tremendous. So thank
14 you for your commitment. You've risen to the
15 occasion, and it's just been tremendous.
16 We've talked a lot today about so many
17 different issues which you are -- you're
18 involved in each of them, pretty much, when
19 it comes to addiction. And I was questioning
20 the commissioner earlier today about some of
21 the barriers. And you list out, and you do a
22 great job of that, about what is needed and,
23 with the right funding, the services you'll
24 be able to provide.

1 I wanted to ask you about some of the
2 direct obstacles that you see to access to
3 medical-assisted treatment, but particularly
4 to methadone. When I was asking the
5 commissioner, the commissioner didn't want to
6 comment on anything related to Medicaid.
7 Would you be able to tell us what
8 you've seen in terms of access to methadone,
9 any of the major roadblocks, or suggestions
10 that you see that we could be doing to make
11 it easier to access that type of treatment?
12 MS. SMITH-WILSON: Well, I think as
13 the commissioner kind of touched on, it is a
14 very complicated issue with regards to having
15 individuals be able to bridge certain scrips
16 when they leave. And because of all of the
17 issues that are tied with Medicaid, it
18 becomes a complicated issue.
19 And I think for our folks, we just
20 simply want, to be honest, for you guys to
21 figure it out. Because our folks are the
22 ones that are leaving treatment facilities,
23 jails or outpatient or even at the ED, our
24 folks are the folks that are leaving and not

1 having the medicines that they need.
2 And so we have tried to support in any
3 way that we can by providing testimony from
4 individuals, by collecting data. We do a lot
5 of surveys, and anytime there's any issue
6 that our community is facing, we will put
7 together a survey to really collect that data
8 and to really be able to drill down and apply
9 recommendations that the community has kind
10 of validated and authenticated and that is
11 real, that is happening for them on a daily
12 basis.
13 And so I would say that it is a
14 complicated issue, one that we are hopeful
15 that in the coming years we can begin to
16 really kind of mitigate. And folks will have
17 the necessary medications that they need as
18 they leave facilities.
19 SENATOR CARLUCCI: Okay, thank you.
20 I was going to ask -- I know we're out
21 of time, but we'll talk further about it --
22 but the access to supportive housing and the
23 barriers that are there.
24 MS. SMITH-WILSON: Oh, yes, that

1 remains. That was a -- we did a survey at
2 our recovery conference in October. Over 150
3 people were surveyed, and that was at the top
4 of our list.
5 So Stand Up for Recovery Day, we will
6 definitely be talking about housing.
7 MS. WEINGARTEN: Yup. Tuesday,
8 February 11th, I know many of you are going
9 to be there. So we're excited to have you
10 there to listen to the voices of the people
11 in recovery.
12 And thank you for all that you do. We
13 want to work together, continue to work
14 together.
15 CHAIRWOMAN WEINSTEIN: Thank you for
16 being here today.
17 Next we have Legal Action Center,
18 Christine Khaikin and -- Wendy Burch was
19 before, so I assume that's not accurate.
20 MR. ROBINSON: What about Research for
21 a Safer New York?
22 CHAIRWOMAN WEINSTEIN: Oh, I'm sorry.
23 Research for a Safer New York. Please. Ken
24 Robinson.

1 MR. ROBINSON: Thank you. I didn't
2 want to miss my turn.
3 CHAIRWOMAN WEINSTEIN: Not to worry.
4 It's the bright lights.
5 MR. ROBINSON: Good afternoon. As my
6 written testimony indicates, my name is Ken
7 Robinson, and I am the executive director of
8 Research for a Safer New York.
9 Research for a Safer New York is a
10 consortium of harm-reduction providers that
11 has been established to oversee a pilot
12 research study in the form of the operation
13 of five overdose prevention centers in New
14 York State, four in New York City and one in
15 Ithaca. The 24-month pilot study will
16 evaluate the efficacy of OPCs as a crucial
17 strategy to prevent opioid overdose
18 fatalities, reduce public drug use and needle
19 sharing, create a pathway to substance use
20 disorder treatment and recovery, and combat
21 the HIV and hepatitis C epidemics.
22 Most of you probably know that
23 overdose prevention centers are a safe and
24 clean place where indigent IV drug users can

1 consume their drugs under the supervision of
2 staff that have been trained to intervene
3 with naloxone in the case of overdose.
4 OPCs started in Europe in the '70s,
5 and they then spread to Australia and Canada.
6 Multiple empirical studies have been done,
7 and the data has been consistent and it has
8 been clear: OPCs increase access to drug
9 treatment and services.
10 They decrease crime and disorder.
11 They reduce public injection and hazardous
12 litter. They prevent HIV and hepatitis C
13 transmission. And they are cost-effective.
14 Studies indicate that they save the
15 jurisdictions that they operate in millions
16 of dollars by reductions in medical, criminal
17 justice, incarceration, and public sanitation
18 costs.
19 So this is my second year in a row to
20 come before this body to ask you to authorize
21 the Overdose Prevention Center Act. In the
22 meantime, I have met with many of you and/or
23 your staffs to essentially plead with you to
24 support this initiative. Last year we tried

1 to get the OPC Act included in the budget;
2 that failed. Then we tried to get a bill
3 passed, but it never made it out of
4 committee.
5 I have to tell you, my heart has
6 become heavy, because people are dying.
7 We're talking life and death here. I could
8 have done an easy, quick calculation of the
9 people who have died from the last time I
10 testified to this time, but I didn't, but we
11 all know it's a substantial number of people.
12 It really, truly, sincerely is beyond
13 my comprehension that we cannot pass this
14 simple piece of legislation, whose sole
15 purpose is to save lives and to get a very
16 vulnerable and hard-to-reach population into
17 care. Saving human lives should not be
18 controversial. Saving human lives should not
19 be a crime.
20 Esteemed Senators and Assemblymembers,
21 it is time for all of us to show moral and
22 political courage. I know that this bill has
23 negative stigma associated with it, but that
24 is because people do not understand. Most

1 people are good and decent, and it is
2 incumbent upon us to educate them. Passing
3 this bill is simply the right thing to do,
4 and we must do it.
5 A great example of the benefits of
6 OPCs is the Insite program in Vancouver,
7 Canada. Insite was the first OPC in
8 North America, and it's one of the most
9 well-known OPCs in the world. On their
10 website they say that in 2017 they engaged in
11 1,983 overdose interventions and in 2018 they
12 engaged in 1,466.
13 Last July I spoke with Insite's
14 director, Elizabeth Holliday. I was curious,
15 and I asked Ms. Holliday if she would say
16 that each one of those interventions was a
17 life saved. She emphatically replied that
18 she knew with a high level of certainty that
19 each of those of 3,449 interventions was a
20 human life saved.
21 Think about that. That's 3,449
22 families that did not have to bury a son,
23 daughter, brother or sister; 3,449 mothers
24 that did not have to suffer the crushing

1 grief of losing a child.
2 Again, we must authorize the overdose
3 prevention, we must authorize overdose
4 prevention centers this session. One of the
5 lives saved may very well be one of your
6 friends or family members.
7 Thank you.
8 CHAIRWOMAN KRUEGER: Thank you.
9 Senator David Carlucci.
10 SENATOR CARLUCCI: Thank you, Chair.
11 Thank you, Director Robinson.
12 MR. ROBINSON: You're welcome.
13 SENATOR CARLUCCI: I wanted you to
14 elaborate on -- I'm going to ask you two
15 things. First, what are some of the reasons
16 you believe that this legislation has not
17 been passed?
18 And we saw not too long ago, a few
19 months ago, a federal judge rule down the
20 Department of Justice's intervention in
21 trying to strike down a nonprofit provider
22 from doing safe -- overdose prevention in a
23 facility in Philadelphia. And so they said,
24 okay, well -- they were fighting and saying

1 that the Controlled Substance Act of 1986
2 precluded them from doing this. The federal
3 judge said no, they can. Where does put us
4 now?
5 And then also, because that roadblock,
6 it seems to be pushed aside that, okay, we
7 had -- it was against federal law, possibly,
8 to do this. We see that that's not the case.
9 Could you elaborate on that? And also, what
10 are some of the other issues holding up this
11 important legislation?
12 MR. ROBINSON: If it's okay, I'll back
13 up even a little bit more and explain to
14 everybody -- I know some of you know this
15 story, but originally this was going to be
16 done by executive order through the Health
17 Department. The Governor was all in, he
18 promised us that he was going to authorize
19 this. We even saw a draft of the letter that
20 they wrote to authorize it. And
21 Commissioner Zucker, I understand, was
22 holding that letter, just waiting for the
23 Governor to say go ahead. The Governor said
24 "However, I need to wait until after the

1 general election," which we understood, but
2 then we never heard from him again. He just
3 went away.
4 Interestingly, I had -- we had a
5 meeting with his chief counsel, the first
6 time we've talked to them at all since then,
7 earlier today. There may be a glimmer of
8 hope that that could happen. I'm not
9 terribly optimistic about it.
10 So then we switched to the strategy of
11 getting a bill passed, under the leadership
12 of Assemblymember Rosenthal. And I would
13 have to give credit to Senator Rivera too.
14 We all worked really hard, I think, to get it
15 passed last year. The political will just
16 wasn't there, I guess, Senator Carlucci,
17 that's the best thing I could say about it.
18 SENATOR CARLUCCI: Do you believe that
19 the federal court's decision --
20 MR. ROBINSON: Oh, going back --
21 SENATOR CARLUCCI: Yeah.
22 MR. ROBINSON: Well, I have kept up
23 quite a bit with the Philadelphia situation.
24 Everybody knows that the judge ruled in favor

1 of Safehouse, and then the Justice Department
2 pretty quickly said, We are going to appeal.
3 Well, of course they are, we knew that they
4 would do that.
5 Safehouse recently said: We're going
6 to open anyway. We feel we have a stronger
7 case in New York State, because they're doing
8 that just on the authority of the City of
9 Philadelphia. We would be doing it on the
10 authority of the State of New York, who has
11 the authority for an emergency -- we're in an
12 opioid crisis, an epidemic. The state could
13 recognize that as an official emergency, and
14 we would have a much stronger case in court.
15 Through our discussion this morning,
16 there were two or three lawyers in the room.
17 We don't think that they could probably even
18 get an injunction like they got in
19 Philadelphia. That's what the people in the
20 room said this morning.
21 SENATOR CARLUCCI: Okay, thank you.
22 MR. ROBINSON: You're welcome.
23 CHAIRWOMAN KRUEGER: Thank you.
24 Assembly.

1 CHAIRWOMAN WEINSTEIN: Assemblywoman
2 Rosenthal.
3 ASSEMBLYWOMAN ROSENTHAL: Thank you.
4 Good to see you again.
5 Do you think the stigma around being a
6 drug user is abating a bit?
7 MR. ROBINSON: I do. I certainly do.
8 I think that that stigma -- you know, this
9 just crushes my heart. You know,
10 unfortunately, it seems to me people don't
11 value their lives. That stigma is so strong
12 that people just don't seem to care whether
13 they die or not. You know, it breaks my
14 heart.
15 I -- you know, a couple of people
16 today have mentioned about making it
17 personal. I'll make it a little bit personal
18 for me. I'm in recovery, recently in
19 December celebrated 20 years. I'm a former
20 IV drug user. So I've got a passion, I've
21 got a passion to get this done. And I know
22 that stigma firsthand.
23 You know, I'm also a gay man of a
24 certain age, and I saw the government turn

1 their back on us. And they didn't give a
2 damn if we died or not either. And a lot, a
3 lot of people died. Well, I'm seeing the
4 same thing now, it seems like to me, with
5 this group of people. It seems that -- like
6 many -- many, certainly not everybody, but
7 many in government are more worried about
8 political considerations than they are
9 whether or not these people live or die.
10 ASSEMBLYWOMAN ROSENTHAL: Well, I look
11 forward to continuing our work together. I
12 mean, it is an epidemic and it is a matter of
13 life and death.
14 And it's hard for me to understand as
15 well when overdose prevention sites have been
16 legal around the world for years, and here in
17 the United States and in the progressive
18 State of New York, we can't take a step
19 forward when we know it works in saving lives
20 and providing treatment, housing, healthcare,
21 et cetera, for people who need it.
22 MR. ROBINSON: Right. It's become the
23 number-one entryway to treatment in
24 Vancouver, the number-one portal in

1 Vancouver. We would see the same thing here,
2 I'm sure.
3 ASSEMBLYWOMAN ROSENTHAL: Thank you.
4 CHAIRWOMAN KRUEGER: Thank you very
5 much for your testimony here.
6 MR. ROBINSON: Thank you.
7 CHAIRWOMAN KRUEGER: Next up,
8 Christine Khaikin, from the Legal Action
9 Center, and then followed by -- if people
10 want to get ready and come forward -- Mark
11 van Voorst of The Arc New York, and then he
12 will be followed by a panel of Lauri Cole and
13 Andrea Smyth.
14 Good evening -- is it -- wait,
15 afternoon, I take that back.
16 MS. KHAIKIN: Good afternoon. My name
17 is Christine Khaikin. I'm a health policy
18 attorney at the Legal Action Center. And we
19 have a long history of working to remove
20 barriers to health insurance coverage for
21 people with substance use disorders and
22 mental health needs, and so we thank you for
23 the opportunity to provide input today.
24 You have my written testimony, so I'll

1 just focus on a couple of priorities.
2 Last year's passage of the behavioral
3 health insurance parity reforms, a
4 groundbreaking set of policies, made several
5 advances towards improving the ability to
6 access life-saving substance use disorder and
7 mental health treatment. But New Yorkers
8 still struggle to access life-saving
9 addiction and mental health care.
10 For example, they have trouble finding
11 providers with available appointments in
12 their insurance networks, they face delays in
13 getting care because their insurer requires
14 prior authorization, or their care is denied
15 midway through treatment because their
16 insurer says their treatment is not medically
17 necessary. People are paying hundreds or
18 even thousands of dollars out of pocket when
19 they have insurance, due to copays and
20 coinsurance charged higher or more often for
21 substance use disorder and mental health care
22 than for medical care.
23 High-quality providers throughout the
24 state are not accepting insurance or

1 struggling because they receive subpar
2 reimbursement rates for behavioral health
3 services compared to physical healthcare.
4 The state and federal parity laws have
5 made things better, but insurers are still
6 often not held accountable for violating the
7 law. Insurance should help people access
8 care, not prevent someone from receiving
9 treatment.
10 That is why we were thrilled to see
11 that the Executive Budget includes a proposal
12 to require the Department of Financial
13 Services and DOH to promulgate regulations to
14 clarify and strengthen parity compliance
15 requirements. These could provide strong
16 compliance standards so that the regulators
17 can hold plans accountable to follow the law
18 and to not discriminate against people with
19 substance use disorders or mental health
20 service needs.
21 The Executive also proposes to
22 establish the Behavioral Health Parity
23 Compliance Fund, to collect penalties from
24 plans who violate the law. And as we heard,

1 $1.5 million of those funds will eventually
2 go to support New York's mental health and
3 substance use disorder ombudsman program,
4 known as CHAMP.
5 Thanks to the Legislature, in 2018
6 CHAMP became a first-in-the-nation ombudsman
7 program. Operated by OASAS and OMH, CHAMP
8 operates a helpline, run through the
9 Community Service Society, as well as a
10 current network of five community-based
11 organizations that provide on-the-ground
12 outreach and localized support and expertise.
13 CHAMP has served over 1600 New Yorkers since
14 it launched, and it helps people overcome
15 many of the insurance barriers that I cited,
16 as well as connects people to care.
17 While this fund will hopefully
18 eventually provide support for CHAMP, there
19 is a great need now for the Legislature to
20 provide $1.5 million to supplement the
21 current $1.5 million budget for CHAMP. The
22 additional funding will allow a localized
23 network of CBOs to expand to many more
24 counties across the state -- we saw Senator

1 Harckham's map showing there are many bare
2 counties -- and additional money will also
3 help extend the helpline hours beyond a
4 limited time during weekdays.
5 We were also grateful for the
6 Legislature's support for removing prior
7 authorization requirements for all
8 FDA-approved medications to treat substance
9 use disorder. And while we were thrilled to
10 see the Governor sign legislation to remove
11 prior authorization in commercial insurance,
12 Medicaid recipients must also receive this
13 benefit, because administrative barriers
14 should not be getting in the way of receiving
15 immediate life-saving care. And we thank the
16 Legislature for your continued support to
17 make this happen.
18 And I just want to thank you for the
19 opportunity to provide input.
20 CHAIRWOMAN KRUEGER: Thank you.
21 Senate? Well, I have one quick one.
22 So you were here earlier when we were
23 asking the OASAS commissioner questions.
24 What's your opinion about what's preventing

1 the State of New York from just making sure
2 people have continuation of Medicaid coverage
3 from when they're leaving prison to when they
4 get to communities? There seems to be such a
5 disconnect in our inability to get this taken
6 care of.
7 MS. KHAIKIN: Well, I think one of the
8 issues there is the current inability to
9 provide Medicaid inside the walls. And so
10 DOH recently submitted a federal waiver to be
11 allowed to provide Medicaid for the last 30
12 days while people are inside. And that would
13 really help with that transitional care,
14 because it would allow people to get enrolled
15 and begin receiving transitional services
16 even before they leave.
17 And so I think that waiver will be
18 really important. Right now it's with the
19 federal government, so we'll see what
20 happens. But I think that that -- being able
21 to start those transitional services and
22 provide Medicaid inside is a great path
23 forward for that.
24 CHAIRWOMAN KRUEGER: So when they're

1 inside they can get the drug, but you're
2 suggesting that we need a federal waiver to
3 start them a month in advance before they
4 leave jail. But we could still do the
5 application while they're in jail and
6 literally turn it on the day they get out,
7 right?
8 MS. KHAIKIN: Yes, correct. Yes.
9 CHAIRWOMAN KRUEGER: We wouldn't need
10 a waiver for that.
11 MS. KHAIKIN: You would not need a
12 waiver for that, that's right.
13 I don't know if I can speak to all of
14 the reasons preventing that from happening
15 right now, but I do think that that --
16 starting services and Medicaid before people
17 leave would be great. And we'll see what
18 happens with the waiver.
19 CHAIRWOMAN KRUEGER: Thank you.
20 Assembly? No. Thank you very much.
21 Appreciate it.
22 MS. KHAIKIN: Thank you.
23 CHAIRWOMAN KRUEGER: Okay. And as I
24 said, we now have Mark van Voorst, The Arc

1 New York, followed by a panel of two.
2 Good afternoon.
3 MR. GEIZER: Good afternoon. Thank
4 you for the opportunity to speak with you
5 today and provide feedback on the proposed
6 Executive Budget, its impact on our field,
7 and the people that we serve.
8 I am Erik Geizer. I'm one of the
9 deputy executive directors. Mark van Voorst
10 unfortunately could not be with us today due
11 to illness.
12 The Arc New York represents 47
13 chapters across the state who deliver
14 essential supports and services to
15 New Yorkers with I/DD. We are the largest
16 voluntary provider in our field. We support
17 more than 60,000 individuals and families.
18 And we employ almost 30,000 people throughout
19 the state.
20 I've organized my talking points today
21 into five distinct areas which are reflected
22 also in our written testimony, but I'd like
23 to just touch briefly on each of them.
24 The first is #3for5, which you've

1 heard several times today. The Arc New York
2 has joined forces with the New York State
3 disability advocates and the larger human
4 services sector to request a 3 percent annual
5 program funding investment every year for the
6 next five years. This is the same #3for5
7 campaign you've heard today, sector-wide
8 support.
9 Investment keeps pace with inflation,
10 it's aligned with the overall growth of
11 Medicaid funding that the Governor deemed
12 reasonable and expected in his State of the
13 State address.
14 New York has a legal and ethical
15 obligation to provide essential services,
16 quality care, and integration for its
17 citizens with I/DD. Our shared
18 responsibility to the people we support is
19 non-negotiable.
20 The next area I'd like to just speak
21 about is mergers and consolidations. While
22 we appreciate the investment in our DSP
23 workforce, a decade of deferred
24 cost-of-living increases has left our system

1 in crisis. We believe the state is
2 intentionally and systemically underfunding
3 the system to drive consolidation.
4 In the first 65 years of our
5 organization's existence, The Arc New York
6 conducted a total of four mergers, one each
7 decade. Yet eight mergers were completed in
8 the last five years alone, and another five
9 are planned by the end of 2021. A similar
10 trajectory can be seen throughout the field.
11 If the state's goal is increased
12 efficiency, consolidations should be planned,
13 proactive and initiated prior to providers
14 developing into a crisis where services are
15 jeopardized. However, crisis consolidation
16 will continue to escalate in response to the
17 economic constraints our providers face, and
18 OPWDD simply does not have the funds or the
19 capacity at this time to handle the rapid
20 increase in consolidations.
21 COLA deferral has saved the state
22 $5 billion over the last decade. We request,
23 respectfully, that $10 million in state share
24 funding be reinvested from that savings to

1 support the cost of additional consolidations
2 occurring in the upcoming year.
3 In addition to the current financial
4 pressure on providers, the release of the
5 Executive Budget has raised further concerns
6 about cuts to program funding the system
7 simply could not sustain.
8 Managed care. The 2020 Budget
9 Briefing Book included language which clearly
10 articulated that funds required to transition
11 to a managed care environment would be
12 covered by the global Medicaid budget. This
13 year the briefing book is silent on the
14 matter. This omission is deeply concerning
15 for our organization.
16 Funding for the implementation and
17 operation of managed care cannot come from
18 the operating budgets of providers delivering
19 supports and services to the people with
20 I/DD, or from existing resources of the OPWDD
21 system. Any attempt to do so will result in
22 the creation of a financial crisis that will
23 rapidly and irreparably damage the service
24 system before any positive outcomes can be

1 derived from managed care.
2 Deferred rate action. On their budget
3 briefing call, OPWDD indicated there is
4 insufficient funding in the budget to fully
5 fund provider costs moving forward, based on
6 the most recent rates. We are grateful that
7 OPWDD shifted funds to fully reimburse
8 providers through July 2020. However, we
9 have been told to expect a budget neutrality
10 factor of less than 1 that will be applied in
11 July, in an effort to recoup $30 million in
12 state share funding.
13 In his testimony today,
14 Commissioner Kastner indicated that the
15 budget neutrality factor will cut all
16 rate-rationalized programs by 2 percent,
17 significantly more than we estimated. This
18 cut would drive already strained providers to
19 the brink and would escalate crisis mergers
20 beyond the current unsustainable rate. We
21 request that the $30 million be included in
22 the Executive Budget to fully cover actual
23 costs for the fiscal year.
24 Our organization wants to partner with

1 state leaders. But to do so, we must be
2 informed, we must have clarity of direction
3 necessary to plan thoughtfully and invest
4 proactively in the future of our service
5 system. Today I urge not only your
6 investment, but your transparency. We have
7 far more questions than clarity about the
8 transition to managed care and the
9 preparation and investment that will be
10 necessary to transform our field.
11 We believe the state is driving the
12 field towards consolidation, but we have no
13 definitive picture of New York's plan for our
14 service system or its expectations for
15 providers. To be effective partners with the
16 state in serving people with I/DD, we need
17 the administration to be clear about its
18 vision for the future of our field.
19 And lastly, we will work to identify
20 solutions and be strong partners in achieving
21 our shared goals. To do so effectively and
22 to fulfill our mission and our responsibility
23 to the people we serve, we need the state to
24 clearly define the path forward.

1 CHAIRWOMAN KRUEGER: Thank you. Thank
2 you very much for your testimony today.
3 MR. GEIZER: Thank you.
4 CHAIRWOMAN KRUEGER: Next up, Lauri
5 Cole, executive director, New York State
6 Council for Community Behavioral Healthcare,
7 and Andrea Smyth, executive director,
8 Coalition for Children's Behavioral Health.
9 MS. COLE: Good afternoon.
10 CHAIRWOMAN KRUEGER: Good afternoon.
11 MS. COLE: Good to see you all. Thank
12 you for being here and staying in the game
13 this afternoon.
14 My name is Lauri Cole. I'm the
15 executive director of the New York State
16 Council, as you've said. And just to put it
17 on record, it's 20 years for me before this
18 entity.
19 And in addition to being a membership
20 association director representing mental
21 health and substance abuse providers around
22 the state, I'm also a family survivor, twice
23 over in the last two years, both losses to
24 the opioid epidemic.

1 Everything that I say here today and
2 that you've heard before me is largely
3 related to the -- everything that I see is
4 through the lens of access to care. Without
5 it, without adequate access and continuity to
6 care for some of New York's most vulnerable
7 people, we are nowhere.
8 There are two public health crises
9 facing us right now with the epidemic, the
10 opioid epidemic, and increasing rates of
11 completed suicides in certain populations.
12 Our workforce are like first responders at
13 this point. They are essential staff and
14 should be treated, in that regard, similarly
15 to the way that emergency personnel are often
16 treated.
17 At this point the trauma associated
18 with working in a job as a direct care person
19 who is face-to-face with clients who may be
20 there one day and not there the next, is
21 collective and it's fierce. And it's
22 resulted in all kinds of disadvantages for
23 our field and our sector as it relates to
24 being able to recruit and retain staff.

1 Andrea and I are both part of the
2 #3for5 coalition, and I'll tell you that it
3 is an unprecedented group of individuals.
4 And we are looking for something more than a
5 COLA. It is not that we're not appreciative,
6 but instead it is that roofs need repair,
7 health insurance bills go up, all kinds of
8 expenses that we cannot control go up every
9 year, in addition to recruitment and
10 retention issues, et cetera.
11 So while we appreciate the COLA, and
12 we needed it, we need something more. We
13 need an investment, an infusion of resources
14 into our human services sector.
15 There is money to be had this year. I
16 want to remind you of that. I try and do
17 that every year. There is a whole lot of
18 money potentially proposed through DSRIP, and
19 you'll hear about and see that a coalition of
20 advocates is looking for a set-aside of DSRIP
21 funds for community-based organizations,
22 where in the past in DSRIP 1.0, we got a
23 smidgen of those dollars for the
24 community-based care side.

1 In addition to that, we continue to
2 urge you to take a look at the Healthcare
3 Transformation Fund account. That is the
4 fund where Centene-Fidelis and other formal
5 business transaction monies go and where
6 hospitals and nursing homes received a
7 disbursement this past spring. We do not
8 begrudge our colleagues that money, but by no
9 means do we think -- the legislation, the
10 statutory legislation does not stipulate that
11 it is only for a portion of the healthcare
12 sector.
13 Now, that account is controlled by the
14 Governor, and we just urge you to look at it
15 and perhaps to speak about it and perhaps
16 even to advance legislation that would put
17 you in the mix in terms of that discussion,
18 because we need you as champions.
19 In addition, I'd like to just also
20 point out to you that there's money related
21 to settlements to come -- the opioid
22 settlement being one, but not the only one.
23 The Governor's proposal on parity compliance
24 provides an opportunity for income where

1 there has not been before. I'm hoping some
2 of you will ask me questions about the type
3 of enforcement that's gone on to this point,
4 both in the Medicaid and the commercial
5 space, related to the implementation of
6 Medicaid managed care in our sector. It's
7 been 3 1/2 years, and there have not been
8 very many violations.
9 So with that, I'll turn it over to
10 Andrea, my colleague from the Children's
11 Coalition.
12 MS. SMYTH: Hi. I'm executive
13 director of the New York State Coalition for
14 Children's Behavioral Health. My name is
15 Andrea Smyth. I'm also going to run through
16 five quick issues.
17 Thank you for asking questions about
18 the children's behavioral health expansion.
19 I think pursuant to the previous Arc
20 testifier, you can't start up a program
21 unless you invest in new services. And what
22 you heard today was that on January 1st, our
23 startup got cut by 11.5 percent. And yet
24 people are promising that that startup, that

1 expansion, is what's going to address the
2 lack of access to care.
3 And I don't see how you start up and
4 grow a program without the available startup
5 funds. And the startup funds were not on the
6 streets long enough. And they were paid
7 through each individual child that got
8 services as an add-on to the rate, and we
9 think less than 700 kids got the services.
10 So the startup funds to expand the
11 children's behavioral health capacity were
12 not paid out. They're being limited by the
13 Medicaid global cap. We've got to figure out
14 the auspice between this committee and the
15 Medicaid committee and what we're going to do
16 about the Medicaid global cap.
17 The reason why there isn't an
18 expansion in children's and family treatment
19 and support services is because the Medicaid
20 global cap is suppressing what they said
21 they're going to invest in new services to a
22 very small number -- $15 million -- under the
23 global cap. So even if they say we need $60
24 million to spend on children's behavioral

1 health services, they're only going to commit
2 to $15 million. And they will commit to
3 $15 million from now until we change the
4 global cap, so.
5 As Lauri indicated, we also are
6 joining all of the human services field to
7 talk with you about #3for5 funding to help
8 communities thrive. The COLA has not been
9 consistently funding; you've all acknowledged
10 that. But my organization doesn't believe
11 that the patchwork of alternatives is
12 long-term sustainable for the nonprofits.
13 And so by investing in the community-based
14 service system, this year, with the first
15 year of a five-year commitment of 3 percent,
16 we believe we'll get on the right foot.
17 I'm hoping that you will look to other
18 tables to help us with our workforce
19 problems. The Governor proposed last year
20 $175 million in statewide workforce
21 development initiatives. We hope that the
22 human services chairs will look towards
23 adding a new human services workforce
24 initiative.

1 Specifically, one of the key reasons
2 why people are dissatisfied with the
3 low-paying human services jobs -- the second
4 reason. Low-paying is the first
5 dissatisfaction. The second reason is
6 overwhelming paperwork.
7 And we think if you had a legislative
8 roundtable that talked about how the human
9 services field could use the robotic process
10 automation to reduce paperwork, and you
11 invested in our ability to train people to do
12 that work and to come and work for us, that
13 we would start to have some productivity
14 improvements in the human services workforce.
15 So we really urge you to carefully
16 take a look at that. We are going to apply
17 under the existing workforce funds. We're
18 working with UIPath and Gigster, nationally
19 known social impact bond corporations, to put
20 together the proposal. But if we do it,
21 there won't be a way for other human services
22 agencies to do it unless you do a human
23 services workforce initiative.
24 We heard with interest that the

1 $350,000 from OASAS for loan forgiveness was
2 announced today, and we think that's great.
3 And I've spoken with Senator Harckham about
4 the fact that doing loan forgiveness for
5 addiction professionals joins the
6 $3.9 million that's in the budget for
7 Senator Pat McGee's loan forgiveness for
8 nurses and $1.7 million, through
9 Senator Savino, for the LCSW loan forgiveness
10 program, $50,000 for the child welfare worker
11 loan forgiveness program, zero for the
12 children's mental health, licensed community
13 mental health, licensed creative arts
14 therapists, licensed marriage and family
15 therapists.
16 It's okay if we want to do this all
17 piecemeal. It's fine. I'll ask you for
18 $250,000. I'll go out and get a
19 philanthropic match to make it $500,000. I
20 can't retain my clinicians who come out of
21 graduate school with a six-year degree with
22 $120,000 in loans at a $39,000 annual payment
23 rate if I can't offer them loan forgiveness.
24 It's vitally important that we address it for

1 all fields.
2 Last year Senator Carlucci and
3 Assemblywoman Gunther put in a revision to a
4 loan forgiveness program. But we ask you one
5 way or the other to make sure it hits the
6 children's mental health field.
7 CHAIRWOMAN WEINSTEIN: Assemblywoman
8 Rosenthal.
9 ASSEMBLYWOMAN ROSENTHAL: Hi.
10 Thank you. Thank you both.
11 I have a question for Ms. Cole. I'm
12 interested about the availability of MAT
13 prescribers across New York State. I know
14 that there are not enough medical
15 professionals who have the waiver and are
16 allowed to prescribe.
17 So I wonder if you would talk about
18 that and ways that we could increase the
19 number so that more people would have
20 availability.
21 MS. COLE: Thank you for asking that
22 question.
23 It's a big state, and certainly there
24 are qualified, ready physicians, medical

1 staff who are prescribing MAT. However,
2 federal regulation combined with some turf
3 issues in New York State around scope of
4 practice create a volatile situation where we
5 are not maximizing the workforce that is the
6 most interested, the most ready, and the most
7 motivated to provide MAT. And those would be
8 people who currently are operating under
9 caps, arbitrary caps due to federal
10 requirements.
11 One of the ways we can solve this
12 problem, particularly in areas of the state
13 that are not in concentrated urban settings,
14 but also in rural areas of the state, et
15 cetera, would be to focus on what can we do
16 to incentivize those individuals -- nurse
17 practitioners, psychiatric nurse
18 practitioners -- in order to want to do this.
19 This is not easy work. That's why
20 there are probably lots of slots available in
21 a doctor's practice that are not filled to
22 the limit with clients who need MAT because
23 perhaps some potential prescribers do not
24 want to do this work. We need to identify,

1 recruit, retain individuals who do want to do
2 it.
3 And in order to do that, we have to
4 look at scope issues. We have to look at
5 what we can do to be flexible around federal
6 regulations, and we've begun that discussion.
7 But access to care begins with access to
8 appropriate medications.
9 ASSEMBLYWOMAN ROSENTHAL: Is it
10 federal law that -- I mean, for example, are
11 we allowed to say every physician should be
12 able to prescribe bu?
13 MS. COLE: There's an educational
14 component that they have to complete. And
15 sometimes for a prescriber who -- or a
16 potential prescriber who has a busy practice,
17 that may not be desirable.
18 ASSEMBLYWOMAN ROSENTHAL: But it's not
19 preempted by the federal government, is my
20 question.
21 MS. COLE: There are preemptions
22 around the number of clients you can carry on
23 a caseload.
24 ASSEMBLYWOMAN ROSENTHAL: Right. But

1 not how many people can write a prescription.
2 MS. COLE: I don't believe so.
3 ASSEMBLYWOMAN ROSENTHAL: Okay. Well,
4 I'd love to work with you on that.
5 MS. COLE: Thank you.
6 ASSEMBLYWOMAN ROSENTHAL: Thank you.
7 CHAIRWOMAN KRUEGER: Thank you both
8 very much. Appreciate it.
9 MS. SMYTH: Thank you.
10 ASSEMBLYWOMAN GUNTHER: I think I have
11 one.
12 Could you shed some light on the
13 disparity in rates between commercial and
14 Medicaid and what they pay?
15 MS. COLE: Yes.
16 ASSEMBLYWOMAN GUNTHER: The other
17 thing I thought when you were just talking
18 about physicians, there's a lot of physicians
19 that -- you know, it's a tedious practice
20 when you do MAT, medication- assisted
21 treatment, and a lot of doctors still had in
22 their mind this picture of those that take
23 drugs. They don't realize it's the
24 stockbroker with the suit on and those kinds

1 of things. So it's about -- it's a stigma
2 issue a lot of times.
3 MS. COLE: That's right. That's
4 right.
5 ASSEMBLYWOMAN GUNTHER: And I think
6 that -- you know, I know that in my -- kind
7 of my own research, people travel miles and
8 hours away to pick up their methadone in the
9 morning because they don't want to be seen
10 walking in and out.
11 However, if it were some simple doctor
12 that -- or not a simple doctor, but a doctor
13 that had all kinds of things going on, you
14 wouldn't have to charge in error because no
15 one would know your business, for instance.
16 MS. COLE: Yes.
17 I'll just tell you, as a partner in
18 the state's ombuds program, we spend an awful
19 lot of time watching people travel great
20 distances to access care. And that's why the
21 proposal that Christine spoke about earlier
22 that would fund the ombuds program beyond the
23 initial 1.5 is so important, because in your
24 communities around the state, probably most

1 of you do not have community-based
2 organizations that are set up and that are
3 working with the ombuds program to provide
4 local coverage.
5 ASSEMBLYWOMAN GUNTHER: And they work
6 in silos also.
7 MS. COLE: That's right. That's
8 right.
9 But to your question about commercial
10 versus Medicaid rates, we've testified for
11 close to a decade, the council has, that
12 unlike other areas of the healthcare sector,
13 in the behavioral health sector it is the
14 Medicaid rate, the Medicaid managed care
15 rate, that is consistent, stable and
16 government actuarially set. Okay? That is
17 called an APG government rate.
18 On the commercial side, over the last
19 10 years the New York State Council has asked
20 the Department of Financial Services over and
21 over and over again to take responsibility
22 for the inadequate rates that commercial
23 payers -- that is, private health plans --
24 are permitted to pay that are not in any way

1 near cost of care, let alone the Medicaid
2 rates which the state has set.
3 And so what is created is a disparate
4 system in which, interestingly, people with
5 private health insurance, with commercial
6 health plans, people who are underinsured,
7 working-class people every day struggle to
8 find access to care in those same clinics,
9 with the same staff, with the same provider
10 as a person who would show up at the clinic
11 with a Medicaid card in his hand.
12 It is incredible. The state continues
13 to permit it. What we've asked the
14 Department of Financial Services to do is to
15 take responsibility and seek statutory
16 purview to set actuarially sound commercial
17 rates so that we do not have this disparity
18 in rates between commercial clients and
19 Medicaid clients.
20 CHAIRWOMAN KRUEGER: Thank you very
21 much, both of you.
22 MS. COLE: Thank you.
23 CHAIRWOMAN KRUEGER: Next up, New York
24 Disability Advocates, Susan Constantino, and

1 I believe New York Alliance for Inclusion &
2 Innovation, Michael Seereiter. And there was
3 a third, but they did not submit testimony,
4 so I'm double-checking, Yvette Watts and the
5 New York Association of Emerging &
6 Multicultural Providers as well. Did we get
7 testimony from Yvette Watts? Yes.
8 MS. WATTS: Good afternoon, Chairwomen
9 Krueger and Weinstein, Senator Carlucci,
10 Assemblymember Gunther and other members of
11 the Senate and Assembly. Thank you.
12 My name is Yvette Watts, and I'm the
13 executive director of the New York
14 Association of Emerging & Multicultural
15 Providers. But the title that I'm most proud
16 of is I'm a parent of a 34-year-old woman
17 with autism, who still lives at home with me
18 because of the wonderful services and
19 supports that I received in the span of her
20 life from the volunteer agencies downstate.
21 And I'm able to be here today because
22 of the wonderful services that the DSP is
23 providing for me right now. So thank you.
24 I'm here with my colleagues Susan

1 Constantino from -- she's the CEO of UCP of
2 New York State {sic} -- and Michael
3 Seereiter. He is the president and CEO of
4 the New York Alliance. We speak to you today
5 not as executives of our individual agencies,
6 but as representatives of the New York
7 Disability Advocates -- that's NYDA -- a
8 newly formed coalition of more than
9 300 volunteer providers who are instrumental
10 in delivering services and support to over
11 140,000 New Yorkers with I/DD.
12 While we've come to you independently
13 for years to advocate for the field and for
14 people we serve, today we come as one. Our
15 members hold various perspectives and
16 priorities on some matters, but our single
17 driving goal is shared: The sustainability
18 of comprehensive quality supports and
19 services for New Yorkers with I/DD.
20 Across the state these organizations
21 and the more than 120,000 people they employ
22 provide lifelong, comprehensive,
23 individualized services to support people
24 with I/DD in all areas of their lives. In

1 addition to delivering physical and
2 behavioral health services, they assist with
3 transportation, housing, medication
4 administration, cooking, feeding, developing
5 personal care, community living, employment,
6 and other crucial services.
7 As part of the broad coalition of over
8 40 associations across the human services
9 sector, we are here today to ask the state to
10 facilitate the continuation of this care and
11 to stabilize the non-for-profit sector by
12 providing a 3 percent increase in investment
13 annually for the next five years. We're
14 asking for #3for5.
15 We understand the state is facing
16 financial headwinds. However, achieving
17 #3for5 is crucial for ensuring continual care
18 for New Yorkers throughout the state with
19 I/DD. Right now crucial services are in
20 jeopardy. Over the last decade, provider
21 organizations have received only one
22 cost-of-living funding increase -- that's
23 less than .02 percent -- and have experienced
24 $2.6 billion in cuts, pushing many provider

1 agencies to the brink of insolvency.
2 In a statewide survey that we
3 conducted, nearly half of them have less than
4 40 days of cash in hand. A third of the
5 providers reported having to reduce services
6 or cut programs completely in the last three
7 years due to funding constraints, impacting
8 almost 50,000 New Yorkers with I/DD and more
9 than 30,000 employees who support these
10 individuals. And all over New York,
11 providers are operating with minimal or
12 outdated technology and deteriorating
13 infrastructure. This is really dangerous.
14 Stagnant funding also affects
15 employment. Provider organizations employ
16 more than 120,000 people across the state.
17 The majority of them are women and
18 minorities. Many of these organizations are
19 the largest employers in their counties,
20 playing a vital role in the local economies.
21 Organizations are doing what they can
22 to operate within these constraints, and
23 they've taken a variety of steps to lower
24 their costs, with four out of five having to

1 slash employee benefits to these already
2 underfunded individuals. Yet they are
3 running out of options and simply cannot
4 continue to do more with less.
5 These communities deserve the same
6 access to quality care as every other
7 New Yorker. They deserve opportunities to
8 lead independent, fulfilling lives and
9 participate in their communities. We and I
10 implore you to champion the lives of people
11 with I/DD and to commit to support an annual
12 3 percent investment for the next five years.
13 CHAIRWOMAN KRUEGER: Thank you.
14 MS. CONSTANTINO: Thank you. I'm
15 Susan Constantino, and I am here just to
16 represent the New York Disability Advocates.
17 What I really wanted to do was just to
18 give you a little more information about what
19 these providers are going through. What we
20 had done is in December we did a survey. And
21 currently right now, as Yvette has said,
22 there's 300 providers in the intellectual and
23 developmental disability area. You heard
24 everyone today talking in the whole human

1 service coalition, but I just have the
2 information on the I/DD providers.
3 The providers that we surveyed have
4 really been in their communities for 30, 40,
5 50 years or more. These are agencies that
6 are viable, have always been viable agencies
7 providing support to individuals and their
8 families. But all of a sudden this is not
9 what's going on any longer.
10 As Yvette stated, and we'll go just a
11 little bit deeper, 50 percent of the
12 providers statewide have less than 40 days of
13 cash on hand. Your auditors will tell you
14 that's not a good thing. However, 30 percent
15 of the providers have less than 30 days of
16 cash on hand, and we do know that there are
17 providers that may have 10 days of cash on
18 hand or less.
19 So because #bFair2DirectCare gave us
20 dollars to increase salaries, those dollars
21 came in and went right back out to those
22 employees every single time, but not to the
23 agencies so that we could help their
24 structure.

1 Fifteen percent of our providers
2 indicate that in the current years that they
3 have used up to 75 percent of their lines of
4 credit, the balance on their lines of credit.
5 Some might have $2 million, some might have
6 $15 million, depending on the size of the
7 agency. It doesn't matter -- bigger agency,
8 bigger bills. So they are using those
9 dollars up.
10 And also, which I think is really one
11 of the real critical things that is such a
12 shame in all of this, is that in the last
13 three years the agencies tell us that they've
14 had to either reduce or eliminate programs.
15 They have vacancies in their programs,
16 vacancies that should be filled by people in
17 the community waiting to come in. But they
18 can't bring them in because many of these
19 people who are referred to them have complex
20 needs, complex behavioral needs or complex
21 medical needs. And they would have to put on
22 more staff in order to be able to accommodate
23 them, and they don't have the dollars to do
24 that. So those folks are not getting the

1 service that they need.
2 Years ago, those of us who are old and
3 have been in this field a long time remember
4 what the nonprofits offered to individuals,
5 to our staff, was good benefits. We may not
6 have always been the highest-paid in the
7 community, but we offered good benefits.
8 That's not the case any longer. And
9 over the last two years, what people have had
10 to do is restructure their benefits so that
11 people often -- your employees have to pay
12 more than what they've paid before. They've
13 reduced and restructured their retirement
14 plans so that it's harder for individuals to
15 make it on retirement. And many have had to
16 reduce and/or close programs because they
17 just can't afford what it costs to keep that
18 program running. And, again, all critical
19 services to families that are now being lost
20 to us.
21 What individuals -- what they've told
22 us is that, you know, they have had to
23 really -- and I heard this question
24 earlier -- they've had to really look very

1 carefully at what they do with their own
2 facilities. Can they make all of the repairs
3 that their facilities need, can they afford
4 to put on the roofs, can they afford to do
5 many things. The funding streams are not
6 what they used to be, and those are also very
7 significant issues to us in our communities.
8 They've had to switch vendors, not
9 worrying about quality but worrying about
10 cost, which is not always the best thing to
11 do. And for many of them, they've had to
12 reduce program staffing needs. Now, we all
13 know that one of our main directives is
14 always community inclusion, that's what we
15 need to do. But if we don't have enough
16 staff, and the staff because we've not been
17 able to pay them, then we're not able to do
18 that.
19 So I think -- and within there, and
20 we've totally been appreciative of the -- all
21 of the money that came with
22 #bFair2DirectCare. But there are other
23 people who work for us, vital people -- our
24 payroll people, our human resources people,

1 any of our administrative people and
2 secretaries that have been very difficult for
3 us to be able to support any kinds of
4 increases for them -- that's something that a
5 COLA would be able to do.
6 So I guess what I'm saying is that the
7 #3for5 is critical to us right now. This is
8 the only way we're going to be able to keep
9 on. And we are a much better deal than the
10 state. So we are asking you please to
11 consider this.
12 CHAIRWOMAN KRUEGER: Thank you.
13 MR. SEEREITER: Good afternoon. I'm
14 Michael Seereiter of the New York Alliance
15 for Inclusion & Innovation. Thank you.
16 I'd like to start with a thank you to
17 you for your ongoing support and the support
18 from the Governor for our workforce, which is
19 really the backbone of the I/DD industry and
20 the sector. We're very pleased to see the
21 increase for the #bFair2DirectCare campaign
22 and the effort, reflected in the Governor's
23 budget, for a 2 percent increase this year
24 taking effect on April 1st.

1 I would say that wages, I think, are
2 only part of that equation, however. I think
3 that another piece of that puzzle to address
4 what is a huge workforce challenge for our
5 sector is also a credential. And we would
6 support -- we would urge resources to be
7 supportive of the piece of legislation
8 sponsored by Senator Carlucci and
9 Assemblymember Gunther related to a DSP
10 pilot.
11 I would like to quickly address
12 something the commissioner addressed earlier,
13 speaking around DSP wages and the fact that
14 New York State enjoys DSP wages that are
15 typically higher than most other states. I
16 think the question really needs to be asked
17 about what is the cost of living in New York
18 State as it relates to those wages. And
19 furthermore, what is the value of the
20 supports and services the direct support
21 professionals provide? I would argue it is
22 not minimum wage work.
23 So we are indeed pivoting our advocacy
24 efforts, and we're very pleased to be working

1 with the New York State Disability Advocates
2 and the larger #3for5 campaign for the
3 3 percent increase each year for five years,
4 as my colleagues here have more eloquently
5 articulated today than I will. I will say
6 three quick things about this.
7 Number one, the flexible resources we
8 seek would do three things. One, it would
9 stabilize the sector. Number two, it would
10 provide the opportunity for provider
11 organizations that operate in the sector to
12 be planful about their futures. And lastly,
13 it would actually allow us to continue the
14 workforce investments that began under the
15 #bFair2DirectCare campaign.
16 One of the things that -- well,
17 another thing that Commissioner Kastner
18 articulated earlier was that the cost-based
19 methodology that currently is the methodology
20 by which provider organizations are funded in
21 this sector is probably the most favorable of
22 any of the structures. I would say that
23 that's probably true. However, that's not
24 necessarily true when you artificially

1 suppress those rates with a budget neutrality
2 factor or other across-the-board reductions
3 like those that were articulated today.
4 So the rates are indeed less than what
5 it costs to provide services. And just as a
6 kind of -- in passing, those are rates that
7 are reflected two years after the services
8 are delivered. And again, they have not been
9 reflective of any of the cost-of-living
10 adjustments that this sector needs and has
11 not been privy to over a period of about a
12 decade now.
13 On the Medicaid Redesign Team No. 2,
14 we're watching this very carefully and
15 cautiously. We would encourage you to do the
16 same. There seems to be no reason that this
17 process can't improve on the previous process
18 of the MRT 1 in three particular areas:
19 Number one being improved representation for
20 the populations that are impacted; number two
21 being improved stakeholder input; and number
22 three being an improved opportunity for
23 reviewing the recommendations that are
24 ultimately put forward.

1 Lastly, on managed care, we heard
2 today and we've heard through the Governor's
3 budget proposal that the SIP-PL plan
4 qualification document is expected shortly.
5 If indeed the I/DD sector is to continue to
6 move toward managed care, it needs, I
7 believe, four things: Number one, a
8 continued investment in readiness resources,
9 including the managed care community of
10 practice that Senator Seward was asking about
11 earlier, which is a project of the New York
12 Alliance.
13 I will say two things about the
14 managed care community of practice. One is
15 that we are beginning the work to
16 specifically try to address some of the itch
17 points, the concerns related to the CCO
18 implementation, and we are happily taking up
19 some of that work, which will be starting
20 with an inclusive conversation of everyone,
21 all stakeholders involved in the system.
22 Number two, I would say that very
23 shortly we will be delivering to your offices
24 a white paper that discusses the implications

1 for New York State, based on a study of five
2 other states that have already implemented
3 managed care for the I/DD sector, and what
4 can be learned from those experiences.
5 The second on my list of things that
6 are necessary for success in managed care are
7 investments in health information technology
8 to be able to operate in a managed care
9 structure.
10 Number three would be an I/DD
11 ombudsperson program specifically geared for
12 the specific needs of this population. It is
13 a very different population than all of the
14 other populations that have moved to managed
15 care.
16 And lastly, I will quote from the
17 Transformation Panel recommendations from now
18 five -- I believe it was five years ago --
19 to, quote, identify funding to meet the
20 administrative costs of managed care,
21 distinct from funding required to meet the
22 needs of individuals for services.
23 Under no means can the resources
24 necessary to stand up that system come out of

1 the existing system provider sector or, by
2 any means, out of those services and supports
3 that individuals and families rely on on a
4 day-to-day basis.
5 Thank you.
6 CHAIRWOMAN KRUEGER: Thank you.
7 Senator Carlucci.
8 SENATOR CARLUCCI: Well, thank you for
9 your testimony and thank all of you for your
10 commitment to protecting our most vulnerable
11 populations. I share the concerns that all
12 of you addressed today, and I think many of
13 our colleagues do as well.
14 I just wanted to ask you to elaborate
15 more upon -- because we didn't get time to
16 talk about it today -- about the
17 credentialing program, how you see that
18 working and how it will help to give a better
19 experience to the people that are being
20 served.
21 MR. SEEREITER: Several years ago the
22 Legislature appropriated funds to study this
23 program -- study this idea in its totality.
24 And the recommendations that came out of that

1 report really talk about how the credential
2 needs to be accompanied by what is already in
3 the existing system when we talk about core
4 competencies.
5 That's kind of the base, right? And
6 then on top of that you want to start to
7 strive for excellence. And between the two
8 of those things, you start to actually move a
9 system toward identifying those opportunities
10 for improving quality.
11 Quality is a definition that I
12 think -- the definition of quality in this
13 sector is something that is not yet fully
14 defined. In fact, I think we're in the
15 process of that right now.
16 If we are to be playing a role in
17 helping to make that a -- helping to define
18 what that is and certainly improving the
19 lives of individuals with disabilities that
20 these services and supports are designed to
21 do, we need to be striving for that
22 excellence.
23 And in doing so, the credential starts
24 to push the system and it starts to create

1 the opportunities for people who want to be a
2 direct support professional to do this and to
3 make it a career, which is really where I
4 think the secret sauce is. It's in the
5 relationship between the individual served
6 and the person providing those services. The
7 longevity of that relationship, the quality
8 of that relationship drive so much of what we
9 see in terms of the outcomes I think that are
10 possible in this system.
11 SENATOR CARLUCCI: Thank you.
12 And I wanted to -- I just wanted to
13 also thank you for your advocacy for the
14 #3for5 campaign. It's so important that we
15 get the funding into the system.
16 And also I want to thank you for
17 bringing it to the attention that it was
18 stated earlier that our DSPs are paid at a
19 level top in the country compared to other
20 states. And I think it's important that we
21 remind everyone that we really can't be
22 looking to other states. If we want to go
23 backwards, maybe we'll do that, but we want
24 to continue to go forward.

1 And New York is consistently seen as a
2 leader in providing services to our most
3 vulnerable populations, and I think we have
4 to isolate ourselves from that and not look
5 to go backwards but look to go forward and
6 continue to be an example for other states to
7 follow.
8 So I just want to thank you for
9 bringing that point up and really correcting
10 that statement that was said earlier. Thank
11 you.
12 Thank you, Chair.
13 CHAIRWOMAN KRUEGER: Senator Jim
14 Seward.
15 SENATOR SEWARD: Yes, one question for
16 the panel. I know some of you have talked
17 about this in general terms, but I wanted to
18 get your assessment of the CCOs and the
19 impact on services to those that need the
20 services in the DD community.
21 MS. CONSTANTINO: I'll take one crack
22 at it.
23 SENATOR SEWARD: I mean, how's it
24 going, I guess is the --

1 MS. CONSTANTINO: You know, I think
2 for it being a program that's not quite two
3 years old, it's going well, considering what
4 we did and how we totally did away with one
5 whole piece of what we had come to rely on,
6 which was our Medicaid service coordinators,
7 and move to something different. So I think
8 in that regard it's doing well.
9 I think -- and we did hear the
10 commissioner talk today, and I was really
11 glad to hear him say they are meeting weekly.
12 Because we as providers have sent our
13 concerns, because there still are concerns.
14 I think the hardest part is for the
15 families. They were very used to a very
16 close relationship with their service
17 coordinators. Because the CCOs have had
18 to -- they have larger geographic territories
19 and they've had to change how they really
20 have been able to assign people, people have
21 had to get to know new folks. And they've
22 had so much pressure to do the life plans
23 that they probably haven't had as much time
24 to really begin to integrate into people's

1 lives a little bit more.
2 But I think for being a new program,
3 it's really moved along quite remarkably.
4 MR. SEEREITER: I would echo that,
5 actually. I think, you know, when you look
6 at the larger trajectory of implementing a
7 system change of that magnitude -- you're now
8 a year, 19 months into the process, roughly
9 -- I think it has gone along quite well, all
10 things considered.
11 I think there's just also a -- I think
12 there are some fundamental issues that do
13 need to be addressed with the existing --
14 kind of the system that we now have. We're
15 now, again, 19 months into implementation.
16 That's no longer part of the implementation
17 period. But I think that there are
18 expectations that are either unrealistic or
19 don't match up with what the service system
20 is now looking like.
21 I think it is an oversimplification to
22 say that it is simply a shift of the Medicaid
23 service coordination capacity from the
24 previous process to the care coordination

1 structure. That is, it's different. It is a
2 health home model. And the scope and
3 magnitude of the responsibilities of the
4 health home and the care managers who work
5 for them are different than those that work
6 for the Medicaid service coordinators.
7 So setting reasonable expectations and
8 helping everyone understand what the roles
9 and responsibilities are, I think we kind of
10 need to go back and do a little bit of the
11 going back to basics. And that's actually
12 where we're going to try to focus some of our
13 managed care efforts, managed care community
14 and practice efforts, to try to help
15 understand what is it that we can actually
16 expect out of this process and what are
17 reasonable expectations.
18 MS. WATTS: But I can say, as a parent
19 and also as an association rep, that we as
20 parents, we've always worked with OPWDD and
21 the volunteer sector. We've worked very
22 closely with them.
23 So yes, this -- as Susan did say --
24 was a tremendous leap for the families, but

1 they are resilient. And I will tell you that
2 the OPWDD providers, they worked with us and
3 the CCOs. Because the CCOs, many of them
4 were the providers. So it was a tremendous
5 transformation, which I think is starting to
6 find its way. Because as Michael was saying,
7 now they're going back and saying, okay, what
8 were the mistakes? And we're going to work
9 together.
10 And I think that's what is so
11 wonderful, is the collaboration. And if we
12 can get this #3for5, we can continue that
13 collaboration, which parents need to continue
14 to be -- like myself, to continue to work and
15 have quality of life and still maintain your
16 individual at home longer because you're
17 getting the good services from these provider
18 agencies. So it's all a collaboration that
19 needs to continue.
20 SENATOR SEWARD: Thank you for your
21 assessment.
22 CHAIRWOMAN KRUEGER: Thank you very
23 much, all three of you. Appreciate it --
24 MS. CONSTANTINO: Thank you.

1 CHAIRWOMAN KRUEGER: Our next
2 panelists are Alcoholism and Substance Abuse
3 Providers of New York State, John Coppola,
4 and Coalition for Behavioral Health,
5 Amy Dorin.
6 You can start in whichever direction
7 you prefer.
8 MS. DORIN: We're going to start with
9 John.
10 MR. COPPOLA: Good evening. I'm happy
11 to be here.
12 And just want to begin by sort of
13 echoing a point that a number of -- that,
14 Senator Krueger, I heard you make, and
15 Senator Harckham a little bit earlier,
16 Assemblywoman Gunther, Assemblywoman
17 Rosenthal, in terms of talking about the
18 amount of resources that are committed to the
19 crisis. And I think Senator Harckham's words
20 were "drastically underfunded."
21 The magnitude of our response to the
22 public health crisis that's been created by
23 the addiction related to opioids and opioid
24 overdose deaths -- the magnitude of our

1 response has not approximated the magnitude
2 of the crisis. And that's a significant
3 problem.
4 It is not acceptable that -- you know,
5 there's a chart that I included in my
6 testimony that shows the funding for local
7 assistance programs in communities across the
8 state beginning in 2013 and ending with the
9 current year's proposal. And if you think
10 about the work that you did last year, after
11 the Senate and the Assembly were finished
12 adding to what the Governor proposed, the
13 result was a 1 percent increase over the
14 previous year.
15 And that was in a year when we were
16 talking about a record number of overdoses
17 and a record impact of addiction on the
18 system. And when we were all done with the
19 budget, there was a 1 percent increase to
20 help folks address this crisis. Which means,
21 you know, all of the things you've heard
22 people talk about relative to the cost of
23 doing business were somehow, you know, also
24 included.

1 And one of the things that I want to
2 do -- I want to call a little bit of
3 attention to the testimony that Ken Robinson
4 gave a little bit earlier. And he talked
5 about his experience working with AIDS and
6 HIV. And his -- you know, he must have said
7 three or four times "My heart is broken," and
8 he was thinking about the lack of attention
9 that we pay to people who are currently
10 using, you know, drugs. And, you know, our
11 lack of ability to see the fundamental
12 dignity in those people. And so he was kind
13 of surmising that it was a stigma which was
14 the reason why we were so poorly funded.
15 And I want to call your attention to
16 what happened specifically with AIDS/HIV.
17 You all were responsible for a significant
18 change in the response that that illness and
19 that health challenge received, and that was
20 that you increased the rates, the Medicaid
21 rates for physicians who were supposed to be
22 paying attention to that crisis. And as soon
23 as the rates were increased, physicians
24 started coming out of the woodwork to do that

1 work. Absolutely.
2 And I would suggest to you that if you
3 take a page or two out of the playbook that
4 you used in addressing the crisis that was
5 caused by the incidence of HIV and AIDS, that
6 that would go a long way toward helping us
7 address the needs of people suffering with
8 addiction to opioids and other drugs.
9 And I would just sort of suggest that
10 the conversation be much broader than just
11 the opioid crisis. It was alarming to read
12 recently that the number of deaths
13 attributable to alcohol doubled -- doubled --
14 in the last 10 years. And so when you think
15 about, you know, addiction related to
16 alcohol, addiction related to opioids, and
17 we're starting to hear about
18 methamphetamine and cocaine and fentanyl,
19 it's a sizable public health issue.
20 And I believe that if you approach it
21 the same way that you approached AIDS and
22 HIV, look at the Medicaid rates and, you
23 know -- and again, I think that is at the
24 point when Assemblywoman Rosenthal asked the

1 question about why don't more doctors
2 prescribe buprenorphine, why aren't more
3 doctors getting involved.
4 There are a lot of doctors that are
5 certified that are not prescribing to
6 anybody, and they've made a decision that
7 it's not good business for them to do so
8 because the rates don't pay for the cost of
9 doing the service, it's a bad idea. And so
10 there's an inherent discouragement of
11 offering the very service that people are
12 talking about so frequently which is also,
13 you know, medication-assisted treatment.
14 So it really is fundamentally a
15 question of do we have the will to really
16 address this problem and can we work looking
17 at the Medicaid rates.
18 So our first priority this year is
19 indeed the #3for5. And you've heard from
20 everybody that if you don't have an
21 economically viable, fiscally solvent --
22 fiscally sound organization, you are not in
23 the best possible position to address the
24 needs of people in need. And so we stand

1 firmly with our partner organizations in the
2 #3for5 campaign.
3 The second one is really -- which I
4 just identified, is to take a look at the
5 Medicaid rates and to do something with
6 Medicaid rates.
7 And the final point is to look at the
8 possible revenue that you have at your
9 disposal, whether it's the settlements from
10 opioids, whether it's the tax on marijuana
11 for adult users -- if that's something that
12 you legalize -- if it's the Comrie-DenDekker
13 alcohol tax which would literally tax maybe
14 5 cents for a drink, or if there's additional
15 funds that go into the pharma fund. There
16 are resources there if you want to do the
17 job.
18 Thank you.
19 CHAIRWOMAN WEINSTEIN: Thank you.
20 Amy?
21 MS. DORIN: Thank you. Good evening.
22 We really appreciate your convening of
23 this joint legislative public hearing on the
24 2020-2021 Executive Budget.

1 I'm Amy Dorin. I'm the president and
2 CEO for the Coalition of Behavioral Health.
3 The coalition represents more than
4 100 community-based behavioral health
5 providers who collectively serve over
6 600,000 New Yorkers every year.
7 I'm testifying today with my colleague
8 John Coppola. The coalition and ASAP
9 recently announced a strategic partnership to
10 build a unified voice for behavioral health
11 providers throughout the state, highlight
12 integration as the future of our field, and
13 improve care for individuals with mental
14 health and substance use disorders. We're
15 very excited about this partnership, and
16 together the coalition and ASAP represent
17 about 250 community-based agencies throughout
18 New York State.
19 This is a critical time for behavioral
20 health in New York. The opioid and suicide
21 epidemics are taking the lives of thousands
22 of New Yorkers every year. New York State
23 has the opportunity at this moment to truly
24 invest in behavioral health, tackle these

1 epidemics and emerging issues, and improve
2 public health for the state.
3 Unfortunately, the current funding and
4 support for the sector means that providers
5 lack the flexibility to fully address these
6 issues. Individuals throughout the state
7 frequently encounter waitlists for services,
8 which delays access to care and increases the
9 likelihood of utilizing much costlier
10 services such as the emergency room and
11 inpatient hospitals. Clients also experience
12 staff turnover that is detrimental to their
13 care, as funding does not allow for
14 sufficient salaries.
15 Our first and most important issue is
16 the #3for5 campaign, which I'm sure you've
17 heard all throughout the day. It is
18 absolutely crucial. If we do not invest in
19 our community providers, we're not going to
20 go anywhere or be able to do anything. So we
21 stand with human services coalitions from
22 across New York State calling for the states
23 to invest in a 3 percent increase on
24 contracts and rates for the next five years.

1 Human services funding has been
2 slashed by 26 percent since 2008, resulting
3 in rates that are lower than 1980. The
4 800,000 New Yorkers who make up the human
5 services workforce bear the brunt of this,
6 with stagnant low wages which leave the
7 average human services worker living at or
8 below the poverty line.
9 One of our members today -- and it
10 represents several members -- talked about
11 their workforce that are homeless. They live
12 in homeless shelters, come into work every
13 day to help other people who are also on the
14 brink of homelessness. I think that is quite
15 a statement and very impactful.
16 This chronic underfunding threatens
17 the stability of New York's entire human
18 services sector. Thirty-nine percent of
19 New York's human services organizations have
20 less than three months of cash on hand. If
21 you run an organization, that's very, very
22 scary.
23 Organizations often have just a few
24 late payments -- are a few late payments away

1 from being able to make payroll.
2 Organizations struggle to pay for increasing
3 requirements and demands necessary to conduct
4 business, including widespread adoption of
5 electronic health records, data analytics,
6 cybersecurity -- all part of the cost of
7 doing business.
8 For behavioral health, chronic
9 underfunding has also led to the severe
10 workforce crisis across the state. There's a
11 34 percent turnover rate, an increasing
12 vacancy rate, with behavioral health
13 providers reporting lower-level staff leaving
14 for positions that pay better in retail and
15 food service. And we do have staff leaving
16 to work at Home Depot or McDonald's because
17 the rate of pay is equal to what we're paying
18 or more.
19 This is not easy work to begin with.
20 While it can be immensely rewarding, hours
21 are often inflexible and include nights and
22 weekends, and common incentives like working
23 from home are simply not available to many of
24 the members of our workforce.

1 It is critical that programs are able
2 to staff appropriately to serve individuals
3 with mental health and substance use
4 disorders, but low salaries make it
5 impossible for providers to do so. There are
6 less people coming into the field and less
7 staying in the field -- and that is direct
8 service as well as supervisors.
9 The second issue in our request or
10 ask: Maintaining existing behavioral health
11 funding. We were happy in the first round of
12 cuts when the 1 percent did not affect
13 agencies operating under the Mental Hygiene
14 Law. We need to at least maintain what's
15 happening now, and we must be represented on
16 MRT II since our providers serve the
17 highest-cost, highest-need individuals in the
18 state.
19 Next ask: Ensuring that the opioid
20 settlement funding responds to our epidemic.
21 We will absolutely advocate for the
22 settlement funds to be infused back into the
23 system for substance use prevention and
24 treatment, and we hope that you join us in

1 that.

2 Restore funding for children. This is
3 a huge issue. We can't cut kids -- it has a
4 devastating impact on children, families, and
5 our society. We are requesting a restoration
6 of cuts made to Children and Family Treatment
7 and Support Services, CFTSS, and fulfillment
8 of the state's promise to increase access to
9 services through Medicaid redesign. By
10 bringing children with mental illness, with
11 serious emotional disturbance into
12 Medicaid-managed care --

13 CHAIRWOMAN WEINSTEIN: If you could
14 wrap up.

15 MS. DORIN: I'll wrap up.

16 Children -- in this case, we cannot
17 cut. We've lost so far 25 agencies around
18 the state that have de-designated. That
19 means that they're not going to continue to
20 do CFTSS services for children.

21 CHAIRWOMAN WEINSTEIN: That final --

22 MS. DORIN: Just a concern about CFTSS
23 and the low rates that have caused a lot of
24 providers around the state from

1 de-designating. That means that they cannot
2 do the business of serving children, and it's
3 horrifying.
4 And the last ask has to do with
5 integrating care to improve quality and
6 access. And I'm looking at the model of the
7 CCBHC, the Centers of Excellence for
8 Behavioral Health -- there are 13 in the
9 state, seven in New York City. And really an
10 ask to replicate that model, which allows
11 community providers to have the funding they
12 need to do the services.
13 Thank you.
14 CHAIRWOMAN WEINSTEIN: Thank you.
15 There are no questions. Thank you for
16 being here.
17 MR. COPPOLA: Thank you.
18 ASSEMBLYWOMAN GUNTHER: Well, I
19 just --
20 CHAIRWOMAN WEINSTEIN: I'm sorry.
21 Assemblywoman Gunther.
22 ASSEMBLYWOMAN GUNTHER: So I read -- I
23 try to go along and read along -- you were
24 quick, so it was hard. But, you know, when

1 I'm looking at this, we realize that not all
2 of these requests will be fulfilled. So in
3 my opinion, it's just like my kid's Christmas
4 list -- you know, you've got to go for the
5 ones that are most important to you.
6 MS. DORIN: Yeah.
7 ASSEMBLYWOMAN GUNTHER: And I think
8 that's important. And I think it's important
9 also, can we incorporate into like
10 organizations that already are in
11 communities?
12 I think a lot of the times when I go
13 back to the HIV when that was going on, we
14 used to ID physicians that were already
15 existing in our community, you know, we did
16 it kind of secretly behind -- you know,
17 people would go in.
18 But what I'm saying is that there
19 won't be enough money to support every agency
20 that has come and testified today. So it's
21 almost like we can't be redundant, because
22 there's only a limited amount of money. So
23 how can we get the best bang for the buck
24 without redundancy?

1 I know that you're working together,
2 but I almost think we have to do it just --
3 like it was different interagencies. They're
4 doing lots to communicate together. They
5 want DSPs to get a raise -- to get an
6 increase, so they're working together on
7 those things.
8 Well, as far as we look at the areas
9 of New York State, the agencies that we can't
10 have redundancy -- and the providers. And
11 it's important. And -- because there's only
12 that much money to go around. And you hate
13 to keep saying no to people. So how can we
14 make it more cost-effective with efficacy, is
15 what I'm saying.
16 And, I mean, I think that brilliant
17 minds, they do prevail, and there's got to be
18 some way, because we're not going to get it
19 all. And I know that. And I'm sure other
20 people agree with me. I feel bad when people
21 sit here and are asking for money and I feel
22 like, you know, I'm going to be -- it's going
23 to be disappointing.
24 So how could you not disappoint people

1 and utilize what you have and also
2 collaborate together to provide the services
3 that you really want for our communities?
4 MR. COPPOLA: I think there's two
5 things specific to your point. One of them
6 is to take advantage of the additional
7 resources that we mentioned, to have the
8 conversation about how can we utilize funds
9 from the settlement funds to, you know,
10 distribute in a way that will really make the
11 kinds of changes we're talking about.
12 When we have the conversation about
13 the marijuana tax, if that's something that
14 happens, how do we make sure that we make the
15 investment in prevention and treatment that
16 we --
17 ASSEMBLYWOMAN GUNTHER: But we don't
18 know that it's going to happen. So I'd
19 rather look at what is in front of us,
20 because that -- by the time the tax is, you
21 know, when they start -- if they do get --
22 the tax comes, it's still going to be a
23 length of time before that money will be able
24 to be utilized --

1 MR. COPPOLA: Right.
2 ASSEMBLYWOMAN GUNTHER: -- for
3 anything. So --
4 MR. COPPOLA: So what is in front of
5 you, though, is the results of DSRIP No. 1.
6 And DSRIP No. 1 -- if you say, okay, let's
7 look only at the successful programs that
8 drove savings. And those savings were
9 largely driven by behavioral health
10 organizations where there was a commitment of
11 resources from DSRIP to those programs which
12 drove savings.
13 So that is not only a question of
14 making the investment, that's where the
15 providers can say to you "We can help you
16 close the gap." We can help you -- and I'll
17 give you one concrete example which was
18 incorporated into DSRIP.
19 There was a program in New York City
20 that did case management with 750 folks who
21 had frequent services paid for by Medicaid,
22 and they were given case management and
23 treatment for their addiction. And it saved
24 those 750 individuals who received treatment,

1 saved in the same fiscal year $10 million.
2 When the program increased from 750 to 1500,
3 it saved $20 million.
4 So you have the ability to say, let's
5 utilize what we know from DSRIP and let's
6 project out how much savings will be
7 generated if we make the investment in the
8 community-based organizations that can drive
9 it.
10 ASSEMBLYWOMAN GUNTHER: I agree with
11 you. I agree.
12 CHAIRWOMAN WEINSTEIN: Thank you.
13 MS. DORIN: Thank you.
14 CHAIRWOMAN WEINSTEIN: Thank you for
15 the work you do and for being here today with
16 us.
17 MR. COPPOLA: Thank you.
18 MS. DORIN: Thank you.
19 CHAIRWOMAN WEINSTEIN: Next we have
20 Northern Rivers Family of Services,
21 William Gettman, to be followed by the
22 Association for Community Living, to be
23 followed by Families Together in New York
24 State.

1 MR. GETTMAN: Good evening. My name
2 is Bill Gettman, from Northern Rivers Family
3 of Services. We're a mental health provider,
4 a child welfare provider, and an educational
5 provider in the Capital Region. We serve
6 18,000 children and adults in the 30-county
7 area.
8 Thank you for your time today, and
9 thank you for your public service.
10 I want to address three critical
11 things related to the delivery of services
12 for children and adults across New York
13 State. First, as my colleagues have
14 suggested, we need to invest in the #3for5
15 campaign. The #3for5 campaign is an overdue
16 action by the Legislature and the
17 administration to support the viability of
18 our local not-for-profit sector.
19 Many people think of #3for5 as a
20 shorthand for the workforce, but it goes
21 beyond the workforce. It pays for things
22 like physical security in our schools and in
23 our residences. It pays for the IT costs
24 that allow us to negotiate with managed-care

1 companies. It pays for heaters.
2 As I was sitting here today I received
3 an email from my facilities director, who
4 told me that one of the heaters in the
5 residences had just blown up and we have an
6 $18,000 expense tomorrow. In the past years
7 I could go back to the state, I could go back
8 to our funders -- OMH, OPWDD, OCFS and
9 others -- and look for dispensation. That no
10 longer exists. I have to go out and
11 privately raise that money.
12 So we ask for #3for5. We need
13 predictable funding over the next five years.
14 Related to that is the recommendation
15 from Andrea Smyth and the Children's Mental
16 Health Coalition for an appropriation to
17 support the mental health workforce and a
18 loan forgiveness program.
19 At Northern Rivers this year we
20 piloted a loan forgiveness program for our
21 staff. We privately raised $150,000 to go
22 out and provide monthly stipends to our staff
23 so they would stay and work for us, so they
24 wouldn't be hired away to go to work for the

1 managed-care companies or for the state.
2 In that regard, I have one additional
3 workforce story to share with you. We have a
4 young man who is 18 years old. He lives in
5 one of our group homes, and I'm proud to say
6 he just got a part-time job. He is the
7 assistant shift supervisor at a local coffee
8 store here in the Capital District. He makes
9 $16.85 an hour, and he works as many hours as
10 he can schedule.
11 The staff person who takes him there
12 every day and picks him up makes $13 an hour.
13 And 25 percent of my staff have to work a
14 second job to meet their needs.
15 So again, I encourage you to support
16 the workforce in various ways through loan
17 forgiveness as well as #3for5.
18 Last, I need to touch on the
19 community-based services that are available
20 under the CBFT services, the new Medicaid
21 services. There are large waiting lists,
22 there are turnover of staff, and they're not
23 financial viable.
24 We are a large provider, and we

1 provide these services to several hundred
2 families currently. We will lose $1 million
3 this year based on the current rates. It's
4 not a productivity issue, it's an
5 insufficiency of the rate. If we can't meet
6 this need to break even on this program, we
7 will have to close it.
8 Which gets back to the question that
9 Chair Gunther asked about how do we make sure
10 we're having an impact, because these kids
11 will end up in hospital rooms, in hospital
12 EDs, they'll end up in homeless shelters, and
13 their problems will escalate, therefore
14 costing more Medicaid.
15 So again, I encourage you to support
16 the human service sector through #3for5, the
17 loan forgiveness, and look hard at the new
18 state plan Medicaid services.
19 I appreciate your time and your
20 service and your dedication. This is a tough
21 budget. But I think we need to invest in
22 kids, because kids are our future.
23 Thank you.
24 CHAIRWOMAN WEINSTEIN: Thank you for

1 being here today. Thank you.
2 Next, we have the Association for
3 Community Living, Antonia Lasicki, executive
4 director, to be followed by Families Together
5 in New York State.
6 MS. LASICKI: Hi, good afternoon.
7 Thank you so much for staying and listening
8 for so long. Hi, how are you?
9 I'm going to be as brief as possible.
10 I don't want to repeat a lot of what's
11 already been said here. I do want to start
12 out just by saying that we so support the
13 $20 million that the Governor put in his
14 proposed budget for OMH residential programs.
15 These programs have been underfunded for many
16 years -- some of them did not get increases
17 for 20 years, literally. So it's very much
18 appreciated, and we hope you will support
19 that.
20 Just to put that into context, though,
21 if you take -- we have about 40,000 units of
22 housing operated by not-for-profit providers
23 for people who are -- with serious and
24 persistent mental illnesses who are

1 functionally impaired by those illnesses. So
2 the people with very challenging behavior and
3 medical issues, often on six to 12
4 medications each -- we have people with a
5 high school diploma supervising all those
6 medications, managing that care. Very
7 complicated jobs, as other people have said.
8 And when you think about the
9 $20 million over 40,000 units of housing, it
10 comes out to about $500 per person per bed
11 per year. So it's really -- because the
12 housing system under the Office of Mental
13 Health is so big, it's approximately a
14 billion dollars of their budget. And so
15 $20 million is a 2 percent increase. And
16 when you've gotten nothing for years and
17 years and years, 2 percent is not very much.
18 So we really need that money. It's
19 going to offset other losses. So we -- but I
20 must say, I do appreciate it. It's a very
21 tough budget year. And I did want to just
22 put a couple of things into context.
23 There was a couple of questions to the
24 commissioner about the 2 percent workforce

1 increase, as compared to the statutory COLA
2 that's been deferred 12 out of the last
3 14 years. So the statutory COLA was put in
4 in 2006; we only got it two out of the
5 14 years since then.
6 So what's the difference? So the
7 statutory COLA covers Office of Mental
8 Health, OPWDD, OASAS, OCFS, OTDA, and Office
9 for the Aging. So that's -- the extra
10 COLA was for those six state agencies and all
11 the providers who contracted with those six
12 state agencies.
13 The 2 percent workforce COLA is only
14 for OMH, OPWDD, and OASAS. So those other
15 three state agencies have gotten nothing from
16 the 2 percent workforce increases. They've
17 got nothing for many years.
18 The other thing is, and I think
19 Mike Seereiter spoke about this
20 specifically -- or maybe it wasn't Michael,
21 but -- the 2 percent workforce increase is
22 only for the direct support professionals, as
23 we know. But all those other workers in the
24 organizations are not in that 2 percent.

1 So if you have a worker who is doing
2 data entry for minimum wage -- and we have to
3 enter every single gas receipt, every single
4 expense, it's tedious work -- we have a lot
5 of the workers like that, and they're not
6 part of the 2 percent. So they're left out,
7 even in the OMH, OASAS, and OPWDD systems.
8 So the 2 percent does not replace the
9 COLA that we lost. The COLA that we lost is
10 a completely different animal. And that's
11 why everybody is asking for #3for5, because
12 the #3for5 would take the place of the
13 statutory COLA that we have lost.
14 The 3 percent for five years is a
15 3 percent COLA on the contracts, which is
16 what the statutory COLA would have been --
17 not just for certain workers in certain
18 categories. So the #3for5 is critical,
19 because the longer we go with targeted
20 workforce increases -- yes, we can give a
21 2 percent workforce increase to certain
22 workers, but the agencies are still going to
23 go out of business. They're still going to
24 go out of business.

1 So it makes no -- it doesn't really
2 make a lot of sense to just give a targeted
3 workforce increase and let agencies sink. So
4 we -- I often think about this, the targeted
5 workforce increase idea, as kind of like a --
6 it's kind of a state idea where you're -- you
7 know, you give CSEA workers a raise. You
8 know, there's an arm of the state -- the CSEA
9 workers, they get a raise, but nobody is
10 concerned that the Office of Mental Health is
11 not going to be able to continue to operate
12 from an administrative/managerial point of
13 view. They're still not going to be able to
14 cover their rents, their utilities, their --
15 you know, liability insurance. All that gets
16 taken care of.
17 But for us, it doesn't get taken care
18 of. We get a targeted workforce increase to
19 a direct care worker, and the rest is left
20 alone, and we are -- a lot of our agencies,
21 as you heard, you know, the cash on hand is
22 two weeks.
23 It's really not -- it's not a healthy
24 way to do business, particularly when you are

1 taking care of some of the most vulnerable
2 people in the state, and you don't want
3 providers to go out of business and have an
4 emergency situation on your hands where you
5 have to scramble and figure out how you're
6 going to take care of people.
7 So the #3for5 really takes the place
8 of the statutory COLA. The 2 percent
9 targeted workforce increases are very much
10 appreciated. It's a very tough year, we get
11 that, and we appreciate it. But something
12 else has to be done. We have to move forward
13 in a different way. And I think the #3for5
14 campaign is a campaign that has got everybody
15 on board under all six of those state
16 agencies, all the advocates.
17 And so in terms of Assemblywoman
18 Gunther's question, you know, where do you
19 get the best bang for your buck, I think the
20 #3for5 campaign is probably where you get the
21 best bang for your buck. And -- but again,
22 thank you all for your support, and we'll
23 talk more over the coming months about all of
24 this, I'm sure.

1 CHAIRWOMAN WEINSTEIN: Yes.
2 Assemblyman Santabarbara.
3 MS. LASICKI: Yes. Hi.
4 ASSEMBLYMAN SANTABARBARA: I just want
5 to thank you for being here, and I also want
6 to thank you for visiting my district.
7 MS. LASICKI: I'm sorry?
8 ASSEMBLYMAN SANTABARBARA: I want to
9 thank you for visiting my district and for
10 providing me the information back in
11 Schenectady, Mohawk Opportunities, we had a
12 meeting and it just kind of --
13 MS. LASICKI: I'm sorry. I'm having a
14 hard time understanding you.
15 ASSEMBLYMAN SANTABARBARA: Oh, I'm
16 sorry. I just wanted to thank you for being
17 here and thank you for visiting my district
18 over the summer.
19 MS. LASICKI: Oh, yes, yes, yes, yes.
20 ASSEMBLYMAN SANTABARBARA: Yeah, we
21 got --
22 MS. LASICKI: I really liked that,
23 yes.
24 ASSEMBLYMAN SANTABARBARA: And Mohawk

1 Opportunities -- and executive director Joe
2 was there --
3 MS. LASICKI: Yes.
4 ASSEMBLYMAN SANTABARBARA: -- and
5 provided me information ahead of the hearing.
6 MS. LASICKI: Yes. Yes.
7 ASSEMBLYMAN SANTABARBARA: That was
8 very helpful, because there's a lot to take
9 in at the hearing.
10 MS. LASICKI: Yes.
11 ASSEMBLYMAN SANTABARBARA: So I
12 appreciate you taking the time. And, you
13 know, the homes that we're talking about, the
14 facilities, some of them are not far from
15 where I live --
16 MS. LASICKI: Right.
17 ASSEMBLYMAN SANTABARBARA: They're
18 certainly in my district. And we talked
19 about the City of Amsterdam as well, a new
20 project that's going to be --
21 MS. LASICKI: Yeah. Yeah.
22 ASSEMBLYMAN SANTABARBARA: -- coming
23 online very soon. So I wanted to thank you
24 for -- I know it's a short period of time,

1 but we did review that information and we
2 will be fighting for you in the budget.
3 MS. LASICKI: Great. Great.
4 ASSEMBLYMAN SANTABARBARA: Thank you.
5 MS. LASICKI: Thank you.
6 CHAIRWOMAN WEINSTEIN: Thank you for
7 being here today.
8 MS. LASICKI: Thank you.
9 CHAIRWOMAN WEINSTEIN: Next we have
10 Families Together in New York State, Paige
11 Pierce, to be followed by Jim Karpe.
12 And is Amber Decker here? No?
13 Yes, go ahead.
14 MS. PIERCE: Good afternoon. Thanks
15 for sticking it out.
16 I'm Paige Pierce, I'm the CEO of
17 Families Together in New York State.
18 Families Together is a family-run
19 organization that represents families of
20 children with social, emotional, and
21 behavioral health and cross-systems needs.
22 We represent thousands of families from
23 across the state whose children have been
24 involved in many systems, including mental

1 health, addiction, special education,
2 juvenile justice, and foster care.
3 I am one of those parents. I have a
4 son who's 28 who's on the autism spectrum,
5 and I've been advocating with him and for him
6 over the last 25 years. Our board and staff
7 are made up primarily of family members and
8 youth who have been involved in these
9 systems, and our 2020 policy agenda, which
10 you have in my written testimony, is created
11 by our families.
12 In 2011, when the Medicaid Redesign
13 Team was launched, I was glad to serve as one
14 of the people on the Children's Behavioral
15 Health MRT Subcommittee. The central premise
16 of redesign was that New York would rein in
17 costs by investing in better, more creative
18 preventive healthcare strategies.
19 Back then, we knew that the children's
20 behavioral health system was underresourced.
21 We knew that we had insufficient capacity to
22 meet the needs of our children. The state
23 acknowledged this reality. For children,
24 unlike every other aspect of Medicaid, we

1 resolved that the state would spend funding
2 most effectively by actually investing more.
3 But now, in 2020, despite several
4 delays, the new services are finally here and
5 we must acknowledge a new reality. After
6 nine years, the promised expansion of
7 200,000 newly eligible young people who would
8 be able to access a suite of innovative and
9 evidence-based services known as the Children
10 and Family Treatment and Support Services,
11 CFTSS, has not been realized.
12 These services are designed
13 specifically to be delivered in our homes,
14 schools, and communities instead of waiting
15 for families to reach crisis and rely on
16 emergency rooms, residential placements, and
17 police involvement. Today, only 6400
18 children are utilizing these services -- not
19 because children no longer need them as they
20 did back in 2011. In fact, depression and
21 anxiety are rising among children and
22 adolescents. Seventeen percent of high
23 school students reported seriously
24 considering a suicide attempt. Suicide is

1 the second leading cause of death among
2 15-to-19-year-olds.
3 And we heard earlier about, you know,
4 all of the statistics: 54 percent of
5 children with behavioral health needs don't
6 receive the treatment that they need.
7 Almost a decade since the MRT acknowledged
8 the children’s capacity crisis, the expansion
9 of the children’s service system has been
10 delayed so long and supported so sparingly
11 that the nonprofit community-based
12 organizations and their workforce have been
13 left in disarray.
14 Rates were set drastically lower than
15 the actual cost of delivering these services.
16 Even the enhanced rate during the first year
17 wasn't sufficient to cover costs.
18 On December 31st of last year, despite
19 the outcry from the children's behavioral
20 health community, and with these services
21 barely off the ground, the enhanced rates
22 were rolled back as scheduled. As you heard
23 from the commissioner earlier, that's the
24 explanation for why they were rolled back, is

1 that it was -- that was the schedule.
2 Staff turnover is high, waitlists are
3 common, and in some parts of the state, it
4 can take half a school year to get into a
5 therapy program that serves kids, and they
6 have to travel hours for just an assessment.
7 The bottom line is that despite the
8 fanfare and despite the years of preparation,
9 we are not reaching nearly the number of
10 children the state promised to serve.
11 Cutting rates at this time has not only
12 crippled providers, it has harmed children
13 who will now not have the access to the
14 services that they need.
15 Today, Medicaid is overspent by the
16 standards set nearly 10 years ago. And
17 before the original MRT plan has been
18 realized, a new MRT II will now envision how
19 they can further reduce costs locally. In my
20 experience, I worry that children and
21 families will be caught in the crossfire.
22 They can't, again, be sent to the back of the
23 line.
24 Will children have to wait yet another

1 decade for their needs to be a priority? I
2 hope not. We must put children first. We
3 must invest in services that strengthen
4 families and help young people reach their
5 potential.
6 Evidence is clear that exposure to
7 childhood traumas, known as adverse childhood
8 experiences, ACEs, can lead to poor health,
9 mental health and socioeconomic outcomes
10 later in life, health outcomes that are no
11 doubt driving the increasing costs of
12 Medicaid. Our failure to make investments in
13 the mental health of young New Yorkers a
14 decade ago can't be the reason we don't
15 invest now.
16 What we do this year will impact
17 entire generations of New Yorkers moving
18 forward. That's why we're proud to help lead
19 the Campaign for Healthy Minds, Healthy Kids
20 in calling for a moratorium on all cuts to
21 children's behavioral health services and to
22 restore recent cuts to the CFTSS services.
23 We also join the unprecedented coalition of
24 human service organizations for the

1 #3for5 campaign that you've heard so much
2 about today.
3 Our human service programs are the
4 thing that will drive down the enormous cost
5 of ER visits and unnecessary
6 hospitalizations. You can see in my written
7 testimony the other priorities that we have.
8 We just want to say how much we
9 strongly support the Behavioral Health
10 Priority Compliance Fund holding health plans
11 accountable and enforcing mental health
12 parity laws. We worked for years on the
13 Timothy's Law campaign to ensure that parity
14 was the law of the land, and we need to
15 enforce it now.
16 If we fail to acknowledge the
17 underresourced system and don't invest in our
18 children today, we will most certainly
19 continue to scratch our heads for decades to
20 come, wondering how we can contain costs in
21 human services and address the growing health
22 and behavioral health needs in our state.
23 Please be the progressive leaders that we
24 need and that our children need.

1 CHAIRWOMAN WEINSTEIN: Thank you for
2 being here. And as you said, we have your
3 testimony, it's been circulated to members.
4 So I --
5 MS. PIERCE: Thanks.
6 CHAIRWOMAN WEINSTEIN: No questions.
7 Thank you.
8 Let me just ask again, is Amber Decker
9 here? No. Okay.
10 So then Jim Karpe is going to be our
11 last testifier.
12 MR. KARPE: Thank you.
13 CHAIRWOMAN WEINSTEIN: Thank you for
14 being here.
15 MR. KARPE: Okay. Thank you to the
16 members for sticking it out. It's been a
17 marathon.
18 And here we are to talk about
19 intellectual and developmental disabilities
20 and I'll alert you right away, don't bother
21 trying to follow along with the written
22 testimony, because I'm going to vary widely
23 from it. A lot's been said today, and I'm
24 going to bounce off of some of that.

1 SWAN, for those who don't know, is an
2 independent grassroots coalition of unpaid
3 parents from across New York State. The only
4 stake that we have in this system is the care
5 of our children. I'm one of those unpaid
6 volunteers, and I'm a parent of two young
7 adults with developmental disabilities. So I
8 often say I've got a caseload of two and also
9 a caseload of 200,000.
10 I'm here today really to talk to you
11 about accountability, about holding the
12 system accountable and about holding
13 ourselves accountable for asking the right
14 questions, for looking into all the dark
15 corners. We've done a pretty good job here
16 today, but I'm going to make suggestions
17 about some better work that we can do to
18 continue to probe and continue to hold
19 ourselves accountable and the system
20 accountable.
21 And the first question I have is, why
22 are we moving forward with managed care at
23 all? The state now concedes that this will
24 lead to no savings. So why do it? Perhaps

1 it leads to better quality, but I would read
2 to you one quote from the top of page 4,
3 "There is no definitive conclusion as to
4 whether managed care improves or worsens
5 access to or quality of care." And that's
6 the conclusion of the congressional committee
7 charged with reviewing managed care for
8 Medicaid. So why move forward with it at
9 all?
10 And if we can't save money through
11 managed care, where can we save money? I've
12 got some ideas. One place I can tell you
13 where we can't save money is in comm-hab.
14 Comm-hab right now, community habilitation,
15 serves about 7,000 individuals in New York
16 State at a total cost -- an average cost per
17 person of 23,000. So even if we looked into
18 each of those cases and found some savings,
19 we wouldn't be able to save very much.
20 There is a place where we can save
21 money. There's some big buckets of money,
22 and specifically it's residential services.
23 Residential services --
24 (Mic problems.)

1 MR. KARPE: Oh, I'm sorry. Is this
2 better? Okay.
3 Residential services consume well over
4 half of the OPWDD budget. And within that
5 category, state services consume over
6 $2 billion, at an average cost for state
7 services' IRAs of $233,000 per person. So if
8 we were to find 10 percent savings for those
9 7,000 people, we'd be able to have another
10 7,000 people in comm-hab. And even after
11 finding that 10 percent savings in the state
12 services, they would still cost twice as much
13 as the nonprofit providers for the equivalent
14 service.
15 And that leads me to another question.
16 We have the MRT II busy looking at how to
17 save money. And what makes us think that
18 hospitals and unions will look to themselves
19 for ways to save money? I think it's a
20 tragedy if we allow that to move forward.
21 So I have a list of many other
22 questions, but I'll close with this. What
23 are you, the Legislature, doing to help give
24 OPWDD the flexibility and the power that it

1 needs to actually make change in the system?
2 OPWDD's hands are tied. They don't
3 actually control the licenses of the CCOs,
4 they are -- we've heard today about having to
5 put stuff up to DOH. We've heard about the
6 collective bargaining agreement. What can we
7 do to actually free up OPWDD to change the
8 system?
9 That's the end of my time. I invite
10 you to ask me some of the questions you've
11 asked others, such as how are the CCOs doing.
12 CHAIRWOMAN WEINSTEIN: Senator
13 Jackson.
14 SENATOR JACKSON: Good afternoon.
15 First let me thank you for coming in.
16 And I came in later, so I didn't hear all of
17 the testimony. But you asked a question
18 about what can we do. So I'm sure that you
19 have suggestions for the MRT --
20 MR. KARPE: The MRT II.
21 SENATOR JACKSON: -- II. So are some
22 of those incorporated in here? Or you're
23 going to be submitting those to the design
24 team?

1 MR. KARPE: We can submit them to the
2 design team.
3 It was breaking news about it, and
4 we -- but I would echo Michael Seereiter in
5 saying that it's vitally important that there
6 be representation of all parties.
7 SENATOR JACKSON: On the redesign
8 team, is that correct?
9 MR. KARPE: On the redesign team. And
10 that there be an opportunity to review the
11 results, and that there be actual stakeholder
12 engagement.
13 SENATOR JACKSON: Now, in my
14 understanding -- and you probably know more
15 that I do, because you're following this very
16 closely because of your advocacy on behalf of
17 not only your two adults but, you said, 2,000
18 other people involved.
19 So if we do not agree with the
20 redesign team and do not adopt their
21 recommendations, then we have to deal with a
22 $2.5 billion deficit. One way or the other,
23 do you see the redesign team and them coming
24 forward, whatever they're going to come

1 forward with -- do you think it's going to be
2 positive overall for all of the constituents,
3 your children and others, with regards to
4 children with mental health or developmental
5 disability issues?
6 MR. KARPE: I unfortunately don't have
7 much faith. It's being led by the head of a
8 hospital system and the head of a union.
9 SENATOR JACKSON: And that's why you
10 say it's imperative -- and these are my
11 words -- imperative that you have activists
12 and parents that have been involved from a
13 leadership point of view, like yourself and
14 others that have testified, as part of the
15 redesign team.
16 MR. KARPE: I would concur with your
17 use of the word "imperative." Thank you.
18 SENATOR JACKSON: Well, let me -- I
19 wanted to thank you and everyone else that
20 came in in order to give testimony, because
21 it's extremely important overall.
22 And the leaders here have been here
23 for days hearing testimony; I'm just spotting
24 here and there, being in other hearings. So

1 thank you for coming in and giving testimony.
2 Thank you, Madam Chair.
3 CHAIRWOMAN WEINSTEIN: Thank you.
4 Assemblyman Ra.
5 ASSEMBLYMAN RA: So thank you for your
6 patience in waiting to testify today.
7 So you closed with a potential
8 question to ask you, so how are the CCOs
9 doing?
10 MR. KARPE: So Assemblywoman Missy
11 {Miller} said that she was on her third --
12 I'm on my eighth care manager in 19 months.
13 Before then, I had the same MSC for five
14 years. So just on that metric, I'd say it
15 gets an F.
16 I have -- I have hope for the future
17 that with a lot of hard work, a lot of
18 actually developing the IET {ph} systems that
19 are necessary to gather information, that
20 it's possible to salvage this. But right
21 now, it's -- from my viewpoint as a parent,
22 from the viewpoint of the parents that I
23 speak with, it's just not the rosy picture
24 that you've been presented with today.

1 ASSEMBLYMAN RA: What have you seen in
2 terms of, you know, the reasons why you've
3 had so many? You know, are they just -- you
4 start working with one and then they leave
5 and go somewhere else, or --
6 MR. KARPE: They leave because the
7 work is very frustrating, because there's so
8 much emphasis on metrics versus helping
9 people. People get into this profession
10 because they want to help others, and a large
11 increase in salary doesn't make up for not
12 feeling a sense of purpose.
13 So people are motivated by money,
14 purpose, mastery. You can give people a lot
15 of money -- if they don't feel a sense of
16 purpose, if they don't have a chance to
17 master their tasks, they're going to leave.
18 That's my belief and my experience.
19 ASSEMBLYMAN RA: Thank you.
20 CHAIRWOMAN WEINSTEIN: So thank you
21 for being here and waiting through the end of
22 the hearing to testify.
23 So this concludes the Mental Health
24 Joint Budget Hearing. Committees will

1 reconvene tomorrow morning at 9:30, where we
2 will have joint fiscal committee hearings on
3 the Higher Ed portion of the Executive's
4 budget.
5 Thank you all.
6 (Whereupon, the budget hearing concluded
7 at 5:45 p.m.)
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