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

JOINT LEGISLATIVE HEARING

In the Matter of the
2023-2024 EXECUTIVE BUDGET
ON HEALTH

Hearing Room B
Legislative Office Building
Albany, New York

February 28, 2023
10:02 a.m.

PRESIDING:

Senator Liz Krueger
Chair, Senate Finance Committee

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

PRESENT:

Senator Patrick M. Gallivan
Senate Finance Committee (Acting RM)

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

Senator Gustavo Rivera
Chair, Senate Committee on Health

Assemblywoman Amy Paulin
Chair, Assembly Health Committee

Assemblyman David I. Weprin
Chair, Assembly Committee on Insurance

2023-2024 Executive Budget
Health
2-28-23

PRESENT: (Continued)

Senator John C. Liu

Assemblyman Khaleel M. Anderson

Assemblyman Harry B. Bronson

Senator Brad Hoylman-Sigal

Assemblyman Edward C. Braunstein

Senator Rachel May

Assemblyman Phil Steck

Assemblywoman Marjorie Byrnes

Senator Pamela Helming

Assemblyman John T. McDonald III

Assemblywoman Linda B. Rosenthal

Assemblywoman Jessica González-Rojas

Assemblyman Jake Ashby

Assemblywoman Michaelle C. Solages

Assemblyman Jarett Gandolfo

Assemblyman Josh Jensen

Senator Julia Salazar

Assemblymember Alex Bores

Assemblywoman Jen Lunsford

Senator Lea Webb

Assemblyman Jake Blumencranz

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PRESENT: (Continued)

Senator George M. Borrello

Assemblywoman Nikki Lucas

Senator Kevin Thomas

Assemblywoman Dr. Anna R. Kelles

Senator Samra G. Brouk

Assemblyman Nader J. Sayegh

Senator Nathalia Fernandez

Assemblywoman Jo Anne Simon

Senator Zellnor Myrie

Assemblywoman Gina L. Sillitti

Senator Steven D. Rhoads

Assemblyman Scott Gray

Assemblyman Philip A. Palmesano

Senator James Sanders Jr.

Senator Michelle Hinchey

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CHAIRWOMAN KRUEGER: Let's get started. If everybody would take their seats or stop private conversations and take them outside. Thank you.

(Mic off.) Good morning, and welcome to snowy Albany (inaudible). I'm Liz Krueger, the finance chair of the Senate, and I'm joined this morning by my Assembly partner, the chair of the Assembly Ways and Means Committee, Helene Weinstein.

These are joint hearings. Today is the 11th of 13 hearings conducted by the --

(Mic turned on.)

CHAIRWOMAN KRUEGER: Damn, sorry.

(Laughter.)

CHAIRWOMAN KRUEGER: Let's try again. There you go. Hi. Forget the "damn."

I think you probably already know, I'm Liz Krueger, this is Helene Weinstein -- Finance, Ways and Means.

This is the 11th of 13 hearings conducted by the joint fiscal committees of the Legislature regarding the Governor's proposed budget for the state fiscal year

'23-'24. These hearings are conducted pursuant to the New York State Constitution and Legislative Law.

Today the Senate Finance Committee and Assembly Ways and Means Committee will hear testimony concerning the Governor's proposed budget for the Department of Health, the Department of Financial Services, and Medicaid.

Following each testimony there will be some time for questions from the chairs of the fiscal committees and other legislators from the relevant committees.

I will now introduce members from the Senate, and Assemblymember Helene Weinstein will introduce members from the Assembly. And usually the ranker is Tom O'Mara, but today we have a special guest, the ranker of Health, Senator Gallivan, who will be playing the role of ranker for all the issues today, thank you.

And just to introduce the members of my conference first, I am joined by Senator Gustavo Rivera, the chair of Health; Senator

Webb, sitting on the Assembly side down here. She likes it down there. Senator May, Senator Liu, Senator Myrie and Senator Brouk. And some other Senators may show up as the hearing continues.

I'll hand it to Helene first.

CHAIRWOMAN WEINSTEIN: So for the Assembly we have the chair of our Health Committee, Assemblywoman Paulin. And we have colleagues Assemblyman Bores, Assemblyman Braunstein, Assemblyman Bronson, Assemblywoman Lunsford, Assemblyman McDonald, and Assemblyman Steck. And we probably will have some others joining us.

Mr. Ra, would you like to introduce your colleagues?

ASSEMBLYMAN RA: Sure.

Good morning, everybody. We are joined by Assemblyman Jensen, the ranking member on the Health Committee, as well as Assemblymembers Gandolfo, Byrnes and Blumencranz.

CHAIRWOMAN WEINSTEIN: Senate.

CHAIRWOMAN KRUEGER: And, sorry,

Senator Gallivan will introduce his members.

SENATOR GALLIVAN: We are also joined by Senator Helming and Senator Ashby.

CHAIRWOMAN KRUEGER: So before we get started --

SENATOR GALLIVAN: Hold on, I'm sorry. And Senator Rhoads, of the grand entrance.

CHAIRWOMAN KRUEGER: So before we get started with our first panel, I want to go over some of the basic rules for our budget hearings.

Governmental witnesses get 10 minutes each. Nongovernmental witnesses get three minutes each. All right, and so we'll just go -- since there are three of you testifying on this panel, we will let you go, what, 10, 10, 10, and then we will start questioning.

For legislators to ask questions of witnesses: Chairs Weinstein and Krueger and relevant committee chairs get 10 minutes to ask questions and a second round of three minutes. Rankers get five minutes, no second rounds. All other members get three minutes, no second rounds.

It's especially important for legislators to listen. When you ask a question, that three minutes, five minutes, or 10 minutes includes the amount of time the panel has to answer your question. So please don't do Helene and my least favorite activity. When you have three minutes on the clock, don't ask a 2 minute and 45 second question and then assume somebody's going to be able to answer you.

Same thing if you have five minutes or 10 minutes. Think about leaving time for the answer.

Now, if the answer is actually too long or technical for you to answer in the amount of time given -- that's whether you're a government rep or an advocate or community member -- you can always get back to us in writing. And we might say that to you, Please get us the answer in writing. And if you give it to -- send it to Helene and myself, we will make sure all members of the committees get the answers.

So no matter who asks the question, if

you're following up in writing, get it to the two of us and we'll make sure everyone is getting those answers, which are very helpful.

Nongovernmental witnesses, again, get three minutes. And the members only have three minutes, whether you're a member of the committee, a ranker, or a chair.

The clocks are in obvious places. Yesterday they weren't working so well. Today they seem to be back. So you will hear a sound and see a yellow light when you have one minute left. So don't panic, just realize you only have a minute left, so think through speeding up what you're saying to us or how you're answering.

We have a gavel. We don't use it, really. We think about using it. And we still haven't decided whether we use it on the person or the table. So I'm urging you, don't test us.

(Laughter.)

CHAIRWOMAN KRUEGER: I keep saying that in public. This is going to come back

to haunt me, isn't it? Maybe. Maybe.

So we have as our first panel of guests James McDonald, acting commissioner of the New York State Department of Health; Amir Bassiri, Medicaid director, also with the New York State Department of Health. The acting commissioner is testifying; the Medicaid director is here to answer questions but doesn't have separate testimony.

And then we have Adrienne Harris, superintendent of the New York State Department of Financial Services. And just to clarify, while DFS has many different responsibilities and many different concerns that the Legislature has, she's only here today to deal with issues of health insurance, not -- while I personally love to bend her ear about cryptocurrency, I will not be doing that today in today's hearing. It's just about health and her role in health insurance.

And with that I'm going to ask Acting Commissioner McDonald to speak first, please.

ACTING COMMISSIONER McDONALD: So good morning, Chairpersons Krueger, Weinstein, Rivera, and Paulin. It's great to be here this morning. And I also want to greet the members of the Senate and Assembly health and fiscal committees.

My name is Dr. Jim McDonald. I thank you for the opportunity to testify on behalf of Governor Hochul's FY --

CHAIRWOMAN KRUEGER: Can you pull the mic a little closer? I'm sorry.

ACTING COMMISSIONER McDONALD: I'd be happy to pull it closer.

CHAIRWOMAN KRUEGER: Thank you. Some of them work better than others.

ACTING COMMISSIONER McDONALD: Thank you. You know, and really we're going to be talking about the health and well-being of all New Yorkers. And joining me today is Megan Baldwin, the acting executive deputy commissioner, and Amir Bassiri, our Medicaid director.

You know, by the way, today marks my ninth week on the job as acting health

commissioner. Before joining the Department of Health in July of '22 as the medical director of the Office of Public Health, I spent the last 10 years at the Rhode Island Department of Health in various leadership roles, the last one being the interim director of health, which is analogous to being the commissioner of health here in New York.

Just by way of training, I'm board-certified in pediatrics. I'm also board-certified in general preventive medicine and public health.

I did want to take a moment just to thank Dr. Mary Bassett. And, you know, quite frankly it's an honor to follow in her footsteps here. You know, she really laid a very important groundwork for the department, and it's work that we must continue to do to rebuild the department, and also just to continue to place health equity at the center of everything we do at the New York State Department of Health.

You know, to that end, I am proud that

last year the department created the Office of Health Equity and Human Rights. This office defines the overarching vision, framework and strategy to achieve a diverse, equitable and inclusive department, with the goal of eliminating disparities and advancing health equity to improve the health and wellness of all New Yorkers. This office is staffed by over 600 individuals across multidisciplinary teams, and is essential to advancing New York State's Health Equity Impact Assessment, the Transgender Wellness Equity Fund, and ending preventable epidemics, including HIV, hepatitis C and congenital syphilis.

The FY '24 Executive Budget is a blueprint for better health in New York. Not only does it continue to build on the current fiscal year's historic healthcare investments, but its emphasis on public health infrastructure aligns with the department's focus on health equity. This budget allows us to envision a stronger health system for all New Yorkers that can

meet the challenges of the future while continuing to address persistent health disparities.

To create a healthier future and eliminate health disparities, we must make it easier for people to access primary care. This includes closing the gap on the uninsured, addressing medical debt, and forging pathways to connect New Yorkers with primary care providers. New York enacted several important coverage expansions in the FY '23 budget, including expanding Medicaid eligibility for all adults, eliminating Child Health Plus premiums, and covering mental health benefits. Together, these coverage expansions account for $100 million of new investments and will help hundreds of thousands of New Yorkers.

The Department of Health is also seeking federal waiver approval to expand Essential Plan coverage to additional low-income individuals, increasing our eligibility to 250 percent of the federal poverty level.

Expanding insurance coverage dovetails with our emphasis on connecting more New Yorkers to primary care providers. Governor Hochul has proposed investments in interventions that will ease the way for the underserved to access care. This includes increasing Medicaid reimbursement rates for primary care through an annual benchmarking of Medicaid's physician fee schedule to 80 percent of Medicare's rate; an increase to the nurse practitioner fee schedule; as well as reimbursement for primary care providers for administering adverse childhood experiences, or ACEs, screening.

In addition, the Medicaid program will increase rates for school-based health centers by 10 percent.

The FY '24 Executive Budget also includes various investments to enhance emergency medical services statewide. It provides $7.6 million in increased funding for EMS resources, developing an EMS recruitment and retention program, contracting with EMS agencies for disaster

response readiness, and expanded educational and mental health programs.

Capital equipment resources will be provided to enhance statewide availability of ambulances in areas that need EMS support. The budget also provides innovative delivery models to help reduce pressures of the healthcare system, provide patients with more options to receive care, and bring more medical care into the community.

Additionally, the budget invests over $18 million to increase ambulance provider rates for more complex trips, to further expand access to EMS services across the state.

I'm pleased to report that since creating the Office of Aging and Long-Term Care six months ago, the team has undertaken a great deal of work to support a mission of fostering policy, programs and services that meet the needs of aging and disabled New Yorkers. This includes the creation of Governor Hochul's Master Plan for Aging, in partnership with other agencies, that will

lay the foundation for building safe, livable communities for aging New Yorkers.

The Executive Budget further supports our drive to create a sustainable aging and long-term care system that rewards quality, increases long-term care provider transparency, creates a pathway for caregiver opportunity and flexibility and, most importantly, ensures access to aging services and quality long-term care, while working to eliminate health disparities.

Turning to maternal health, racial disparities remain a significant and deeply troubling problem, with Black women about four times more likely than white women to die from pregnancy-related complications. To address this gap and ensure that pregnancy and childbirth is safe for all New Yorkers, Medicaid coverage for doula services will be expanded for all pregnant, birthing and postpartum Medicaid-enrolled individuals through 12 months postpartum.

To protect our children from the harms of lead exposure, Governor Hochul is

proposing a program to drastically reduce the risk of lead exposure in rental properties, as each year nearly 7,000 children in New York are diagnosed with dangerously elevated blood lead levels.

Governor Hochul's proposal to ban the sale of flavored tobacco products, including menthol, would be a huge step forward for public health. Flavors make it easier for people to start smoking, and harder to quit. Tobacco companies have hooked millions of Black and Hispanic New Yorkers on their deadly products. The Governor's proposal, which focuses enforcement entirely on retailers, not individuals, will protect our children, save lives, and address longstanding racial inequity.

Finally, as we enter a transitional phase in our COVID response, it is appropriate to highlight the critical role that our internationally renowned Wadsworth Labs have played. Recognizing the national significance of Wadsworth, Governor Hochul included a total of

$1.7 billion in her 2023-'24 Executive Budget to build a new, state-of-the-art public health research laboratory in Albany. The additional $967 million, building on top of the $750 million previously earmarked, will allow the five separate sites of the Wadsworth Center to be consolidated within one, at the eastern edge of the Harriman Office Campus, making it easier to coordinate the work of these great labs.

In closing, I want to thank the chairs for inviting me to testify. I look forward to working with you to improve the health and well-being of all New Yorkers. Your partnership is important to me -- and it's essential so we can help ensure your constituents are well-served.

Thank you, and I do look forward to answering your questions.

CHAIRWOMAN KRUEGER: Thank you very much, Commissioner.

And now Supervisor Harris -- Superintendent. Wait, which are you?

DFS SUPERINTENDENT HARRIS:

Superintendent.

CHAIRWOMAN KRUEGER: Thank you.

DFS SUPERINTENDENT HARRIS: Thank you. Good morning. I would like to thank Chairs Krueger and Weinstein, Weprin, Rivera and Paulin, ranking members and all members, for inviting me to testify alongside my esteemed colleagues from the Department of Health.

My name is Adrienne Harris, and I am privileged to have the opportunity to present today's testimony as the superintendent of the Department of Financial Services. DFS's mission is to build an equitable, transparent, and resilient financial system that benefits individuals and supports businesses. Through engagement, data-driven regulation and policy, and operational excellence, the department and its employees are responsible for empowering consumers and protecting them from financial harm; ensuring the health of the entities we regulate; driving economic growth in New York through responsible innovation; and preserving the

stability of the global financial system.

The department regulates the activities of approximately 3,000 banking, insurance, virtual currency, and other financial institutions, with assets totaling more than $9 trillion. DFS provides an average of nearly $1 billion to the state and New Yorkers every year through restitution to consumers and healthcare providers, penalties paid to the State General Fund, and DFS assessment revenue reappropriated to other state entities. The department's operating expenses are assessed upon our regulated entities and are not a cost to New York taxpayers.

I continue to believe that responsible market growth and consumer protection are mutually supporting concepts and not competing concerns. A healthy market grows when consumers have confidence in the products offered and the providers offering them. I look forward to continuing to work with Governor Hochul, the Legislature, sister agencies, and other important stakeholders to

advance policies that support access to quality financial services for all New Yorkers.

It has been 17 months since I joined the department, and I am endlessly proud of what we have accomplished. In this time, DFS has proposed amendments to New York's cybersecurity regulation; issued nation-leading virtual currency guidance on stablecoins, insolvency, insider trading, and blockchain analytics; managed the national-security impacts of the war in Ukraine; finalized a disclosure regulation for small business lenders, and much more.

More broadly, DFS has expanded its focus on kitchen-table issues, taking a more proactive approach to protecting consumers by implementing new laws, promulgating new regulations, issuing regulatory guidance, and returning money directly to New Yorkers in the form of restitution.

Instead of accepting an outdated methodology for check-cashing fees that granted annual automatic fee increases, the

team created a new, data-driven fee structure that considers consumer needs. Instead of acquiescing to historic limitations on what could be done on overdraft fees, the team at DFS issued nation-leading guidance prohibiting unfair and deceptive practices. Instead of viewing climate risk as a self-contained issue, the team made sure that our proposed banking climate guidance did not have unintended consequences for New Yorkers who are already disproportionately impacted by climate change. And instead of accepting the longstanding belief that health equity should be tackled exclusively by public health plans, the department issued a request for data from commercial health insurers to help address health inequities. These are just a few examples of how the department is taking proactive steps to create better outcomes for New Yorkers.

In the unfortunate circumstance where we find, through examinations and investigations, that a company has harmed New Yorkers, we do everything in our power to

make consumers whole. To that end, in 2022 the department returned more than $151 million to New Yorkers in restitution -- more than double the year prior. This is a clear reminder to New Yorkers that their government is working for them.

In addition to the team's tremendous policy and regulatory work, we are working within DFS to rebuild the department around what I call the "three P's" -- policy, process, and people.

When it comes to policy, we have adopted a data-driven approach to policymaking, rather than one based on ideology. The department is engaging more than ever with all stakeholders in order to make decisions that will positively impact New Yorkers.

When it comes to process, it is critically important to me that we strive for operational excellence at DFS, ensuring that decision-making is efficient, transparent, and fair. We have created an operations Division and hired the department's

first-ever chief technology officer to build systems and implement technology required to regulate the fast-moving markets we oversee.

Lastly, I could not be prouder of the people that make up this agency. None of the work at DFS is possible without this dedicated team that continues to produce amazing work, especially given the level of staffing and support available.

Since the merger of the Banking and Insurance departments in 2011, DFS has been staffed at a skeletal level and denied the funding needed to respond to a changing marketplace. Due to the invaluable support of the Governor and Legislature, the FY '23 budget fully funded the department for the first time in its history, allowing the agency to hire staff that had been needed for years. Since January 2022 we have hired 194 new staff and promoted 194 team members, making progress against our five-year strategic plan.

Continuing to hire top talent at a rapid pace is a high priority for FY '24. In

the past year, market turbulence has affected a number of entities that DFS regulates, and in each instance DFS staff have worked around the clock to manage risk and ensure that New York markets and consumers are protected.

Even with the department's recent hiring success, however, historic failures to maintain adequate staffing levels, combined with ongoing attrition -- including attrition to federal financial regulators who pay, on average, 30-50 percent more -- requires us to continue this important work of hiring in order to fully execute our growing mission.

I remain fully confident that with the requisite resources, DFS can cement its role as a preeminent and globally-respected regulator, and New York's place as the financial capital of the world.

As I said last year, I think DFS can best serve New Yorkers by working closely and collaboratively with all of you. I look forward to today's hearing and the work we will continue throughout this budget process and into the future. And I'm happy to take

your questions.

CHAIRWOMAN KRUEGER: Thank you very much.

I know we've been joined by Senator Hinchey.

Any other Republican Senators? Nope. Any Assemblymembers?

CHAIRWOMAN WEINSTEIN: Yes. We've been joined by Assemblyman Weprin, chair of our Insurance Committee; Assemblywoman Kelles; Assemblyman Sayegh; Assemblywoman Simon.

CHAIRWOMAN KRUEGER: And our first questioner will be Senator Myrie, three minutes.

SENATOR MYRIE: Thank you, Madam Chair.

Thank you, Superintendent. Good to see you. And thank you, Acting Commissioner and the staff that have joined --

(Interruption by protesters.)

CHAIRWOMAN KRUEGER: Folks, we're asking you to --

(Continued interruption.)

CHAIRWOMAN KRUEGER: Okay, folks, we're going to ask you to please take your protest outside.

(Continued interruption; mic cut.)

CHAIRWOMAN KRUEGER: -- that you'll just sign up to testify, because I think everybody here today is trying to address the same issues. So we're going to ask everyone who's protesting to please either go back to your seats and listen or leave the room. And I have to ask the four or five gentlemen who have sat down in front to please remove themselves before the Sergeant-at-Arms need to, and we don't want to go down that road.

And again, I don't believe you actually asked to testify, so we didn't refuse you the right to testify. So please respect everybody who is here hoping to get their turn to testify.

(Protestor interruption.)

CHAIRWOMAN KRUEGER: I know. And you came the other week, you're like their --

(Protestor interruption.)

CHAIRWOMAN KRUEGER: Thank you. Thank

you. We're asking you to go now.

(Continued interruption.)

CHAIRWOMAN KRUEGER: Okay, thank you. Thank you. Thank you. And actually it turns out you said you're Housing Works, right? So they did sign up to testify, so let them know they don't have a time later either. Okay? There's no more time for Housing Works after this protest today. You've already used up their time. Thank you.

(Protestor: "That can't happen.")

CHAIRWOMAN KRUEGER: That can be, actually, because I run the Finance Committee today. So please, everybody, excuse yourselves now or take your seats and listen to the other people who are here as well to testify on many issues you care about and we all care about.

(Continued interruption.)

CHAIRWOMAN KRUEGER: Thank you. Okay, can you --

(Continued interruption.)

CHAIRWOMAN KRUEGER: Thank you. Thank you.

(Continued interruption.) Okay, folks -- (gaveling). We're going to take a recess until the protest is over. Thank you for your patience.

(Half-hour recess taken.)

CHAIRWOMAN KRUEGER: Okay. Hello again, everyone. We're going to -- oh, good, we're back on air and I'm back on microphone. And sorry for the inconvenience for those of you who know you're now going to wait even longer before you can testify today.

But to go back to where we were, I believe Senator Myrie was going to be the first questioner.

SENATOR MYRIE: Thank you, Madam Chair. Democracy at work, right?

Acting Commissioner, I was born in a safety-net hospital. I represent four safety-net hospitals in the heart of Central Brooklyn serving predominantly Black and brown patients. And in this budget the Governor has given our safety-net hospitals nothing. Historically our safety-net hospitals struggle. They serve the neediest

patients. We don't have a commercial insured pool. It's a Medicaid-insured pool. They are struggling with their finances. And the state, on a perennial basis, simply offers them one-time shots.

My only question is, What are we doing for our safety-net hospitals? Why is there nothing in the budget for them? We need structural reform, not a one-time shot. And I'm curious as to why we have to make this case every single year, whereas hospitals and other institutions in predominantly white and more affluent neighborhoods don't have to make that case.

ACTING COMMISSIONER McDONALD: So safety-net hospitals are very important to the Governor and to myself and the Department of Health. And, you know, agree with you that, you know, we need our safety-net hospitals; there's no debating that.

I think there actually is quite a bit in the budget for safety-net hospitals, though. Let me walk through a couple of those points, and then I'll go to Medicaid

Director Bassiri to hit some of those points as well.

But, you know, we did do the Statewide III awards. In fact, $200 million just went out Monday. We have $1.6 billion in Statewide for -- that's coming out this year as well. There's another billion coming in Statewide V.

You know, I do think there's other things here as well, you know, for rural hospitals, which are affected by this as well. We do have the direct payment templates, which is about a billion dollars. We have the VAPAP program and Vital Access Provider grants. The 5 percent increase in Medicaid is the largest increase we've had in 20 years.

And, you know, I think there's other things as well, you know, quite frankly, we need to do to help reduce costs for hospitals. One of the things I've heard from every hospital administration is they need to be able to be predict costs, and staffing is a big issue for them.

So I think there's some things we're doing with -- you know, for nursing staffing, in other words, traveling nursing, to help control costs and get some transparency in that space. We're doing some things with Certificate of Need reform which will help some hospitals as well.

And I think we're doing some things with scope of practice as well. You know, scope of practice, to me, there's some modest changes in this budget that I think will help all the hospitals, including safety-net hospitals.

And, you know, just to be clear, there has been a 286 percent increase, you know, in funding of hospitals, safety-net hospitals, since FY '20. The $700 million from last year was a one-time deal -- and I'm sorry, I used up all the time.

CHAIRWOMAN KRUEGER: Thank you.

Assembly. First testifier?

ASSEMBLYWOMAN PAULIN: Thank you. And no, I'm not Helene Weinstein.

(Laughter.)

ASSEMBLYWOMAN PAULIN: My first question relates to COVID-19. The Department of Health and Human Services is planning for the public health emergency at the federal level to expire at the end of May -- or middle of May. What is the expectation at the state level in terms of, you know, when do you anticipate the expiration of the executive order, including the scope issues? And I just wondered if you would comment about the department's readiness relating to the end of the emergency.

ACTING COMMISSIONER McDONALD: Yes, so the end of the emergency being declared by the federal government is May 11, 2023. Important to note that the PREP Act continues till October 1, 2024.

I think when you differentiate the ending of the federal emergency, the national emergency, from biologically and epidemiologically what's going to happen. Because just because May 11th is going to come and go, it doesn't mean the pandemic is gone. Because the pandemic is still going to

be around perhaps another year or two. You know, I think what we've seen is because of the vaccine, because of treatment, because of prevention strategies, we've learned to live with this. You know, which -- that's an important thing. We have learned to live with it.

Is the department prepared for the next pandemic? Yes, we are. You know, we've lost a lot of people, but quite frankly we have a lot of resilient people who've stayed with us.

ASSEMBLYWOMAN PAULIN: I just wonder, you know, do you then expect that the executive order would continue? Because it's the Governor --

ACTING COMMISSIONER McDONALD: So the only executive order left that I'm aware of is Executive Order 4, which is about healthcare staffing. And it's on healthcare staffing, it is not connected to the pandemic directly. So that will continue, quite frankly, I hope not very long. If we get the scope of practice changes through and if we

get the EMS budget changes through, we may not need Executive Order 4 anymore, quite frankly. But what we're hearing from hospitals and nursing homes and from EMS providers right now is they still need Executive Order 4. So we would love nothing more than to move beyond that.

ASSEMBLYWOMAN PAULIN: Thank you.

Next question relates to workforce issues. You know, we -- workforce issues are hitting all sectors of the healthcare community. And I wondered, you know, what approaches that the department is going to be using to address them. And, you know, will it depend or will it be different in different regions of the state?

ACTING COMMISSIONER McDONALD: Yeah, so -- are you asking mostly about how the Department of Health's going to address its own workforce? Or workforce throughout -- healthcare throughout the state? Because they're slightly different.

ASSEMBLYWOMAN PAULIN: You know --

ACTING COMMISSIONER McDONALD: We

could do both.

ASSEMBLYWOMAN PAULIN: Yes. I mean, you could address both. But really primarily nursing shortages, EMS workers, home care aides. You know, the gamut.

ACTING COMMISSIONER McDONALD: Yeah, the gamut. Let's do the gamut.

So yeah, there is the $3 an hour increase for home care workers -- $2 last year, $1 this year. You know, home care workers increasing 32.9 percent since '17, the fastest-growing area of healthcare, period.

You know, for nursing, there is money in this budget for nurses. There's not just loan repayment money, but there's other training money. There's loan repayment for physicians as well.

You know, when it comes to increasing healthcare workers, one of the things we have to be very candid about is they just need time to actually be developed and trained.

You know, I'm a little concerned about our nursing pipeline, quite honestly, about,

you know, we need to be able to train more nurses, but we need nursing faculty to do that. There's only so much of that that the Department of Health controls. I think the scope of practice changes would help. I think interstate licensure compacts, though, are important.

The nursing interstate licensure compact is a lot like the driver's license compact that New York State is part of, where you and I can drive to any state in the country. But could you imagine if we were to, with our New York State driver's license, go to Florida and be told we need the Florida driver's license. That's what we do with the nurses right now.

For the physician compact it's different. But it will definitely help the workforce as well.

I know Medicaid Director Bassiri has some issues here as well. He can give you some more specifics.

MEDICAID DIRECTOR BASSIRI: Thank you, Commissioner. And thank you for the

question, Assemblymember Paulin.

We -- you know, in last year's budget the Governor did enact a $20 billion investment in healthcare and in workforce. It did include the healthcare workforce bonus program in this last year.

ASSEMBLYWOMAN PAULIN: Except this year, you know, with the indexing to minimum wage, we're effectively taking it away.

MEDICAID DIRECTOR BASSIRI: No. That -- this is a bonus payment that has been made to workers through the pandemic --

ASSEMBLYWOMAN PAULIN: Oh, the bonus payment, yes.

MEDICAID DIRECTOR BASSIRI: -- that we spent about $1.5 billion, state investment, to about 600,000 workers in this year. That program will extend for another year.

We also have an 1115 waiver that we're pursuing for the Medicaid program. And in that waiver we have $1.5 billion allocated for workforce that will address what you're referring to with region-specific training and professionals that need to be developed.

ASSEMBLYWOMAN PAULIN: So maybe you can comment or, you know, any of the -- I guess the people on the right, my right, you know, on the issue of -- you know, the issue of indexing the minimum wage and then therefore phasing out the -- or the, in effect, taking away the increase for home care workers.

MEDICAID DIRECTOR BASSIRI: So understand that the index does not include home care workers at this time. However, we did implement a $3 increase for home care workers last year, as Commissioner McDonald said: $2 last year, $1 in -- coming in October. So it doesn't make sense to index at this time because the increase that we've put in place is significantly higher than what that index would be.

ASSEMBLYWOMAN PAULIN: So would you anticipate indexing in the future?

MEDICAID DIRECTOR BASSIRI: I think that discussion is certainly something that we'll be willing to have. Based on our analysis, that would not occur until at least

2029, 2030.

ASSEMBLYWOMAN PAULIN: So, okay, on to a new subject, because I want to get a few more, you know, questions in. Hospital funding. Can you address or tell us, you know, the five hospitals that will take the largest cut in the decrease in the Indigent Care Pool money? And can you assure the Legislature, you know, related to Senator Myrie's question of the safety-net hospitals, that we're not going to see many hospitals go out of business?

MEDICAID DIRECTOR BASSIRI: Yes, I can take that one.

So the first question on the Indigent Care Pool, the reduction will only be to hospitals that do not meet the average government payer mix requirement, which is 78 percent. So if you don't have 78 percent Medicaid plus Medicare payer mix, you would be subject to the reduction.

We actually applied this same methodology of a reduction in 2020. And it's the same hospitals that would be impacted by

that. And they are not safety-net hospitals. Those hospitals are protected from the reduction.

ASSEMBLYWOMAN PAULIN: I assume we'll get a list eventually.

MEDICAID DIRECTOR BASSIRI: You absolutely will.

With respect to the safety-net question, as Dr. McDonald shared earlier, we have been investing in safety-net hospitals through a cadre of different programs. We've been maximizing the federal revenue that we can get match on so that we get as much support as possible to those hospitals.

They're complicated programs, but we are committed to ensuring that the distressed hospitals get the funding they need. We believe the $2 billion that we're allocating for them is sufficient. It does not include the 5 percent rate increase that we're implementing, nor does it include investments in the Essential Plan for inpatient and outpatient --

ASSEMBLYWOMAN PAULIN: So you believe

that the hospitals, we won't have -- we won't suffer from closures as a result of the planning by the department in this budget.

MEDICAID DIRECTOR BASSIRI: We are not expecting any closures.

ASSEMBLYWOMAN PAULIN: 340B. I hesitate to bring it up. Many of the 340B entities will be taking a major hit if we enact the Executive Budget. And the funding for Neighborhood Health Centers in particular is a year-to-year budget add. Shouldn't the funding be guaranteed in the future instead of this method? And, you know, compounding the problem for Neighborhood Health Centers, they haven't been rebased in a long time. you know, is that a consideration going forward?

MEDICAID DIRECTOR BASSIRI: So I'll hold on the rebasing because there's only a minute left. I do want to answer your question on the safety net.

The proposal that we have to keep the health centers whole is a permanent proposal. It is putting in a new methodology into our

state plan amendment, which is the agreement we have with the federal government as to what they'll pay for and what we pay for in the Medicaid program. It's how the rest of their reimbursement is established.

So we are making a permanent investment, and we are reinvesting every single dollar that the health centers have stated they need, directly back to them in such a way that we believe they're actually going to get a benefit and they are not going to be taking a cut.

ASSEMBLYWOMAN PAULIN: So, you know, I'll give up my last 30 seconds because I don't know that I'll squeeze in another question in time, because I get to come back for a second round.

So with that, Senate.

CHAIRWOMAN KRUEGER: Thank you. And you only get three minutes on your second round. Sorry, Amy.

The next Senator is Senator Brouk.

SENATOR BROUK: Can you hear me okay?

ACTING COMMISSIONER McDONALD: Yes.

SENATOR BROUK: Oh, good, I got a good one. Okay, thank you so much, and thanks for your patience today as we're starting a little bit later.

Acting Commissioner, you mentioned doula care in your oral and written testimony, and I think it's crucial that we talk about this issue. You know, we're sitting here in the United States, where you might imagine it is the safest place to have a child; in fact, it is not. It is actually the worst place in the developing world where you would want to have a child, based on maternal mortality rates.

When we look at New York State, we rank 25th in maternal mortality compared to, you know, other states. When we look at places like New York City, Black women are nine times more likely to die in childbirth. Statewide, we are three to four times more likely to die in childbirth. And one of the reasons why doulas are so important is because that is a way that we combat that statistic. We essentially can save babies'

lives and their mothers' lives by making sure that everyone has access to a doula.

For anyone who doesn't know -- someone -- it's a nonclinician who offers informational, emotional, and physical support prenatal, during the birthing process, and postpartum.

So let's dig into the proposal that you brought to us today from the Executive Budget. You say that in this Executive Budget, doula care would be Medicaid-reimbursable, is that correct?

ACTING COMMISSIONER McDONALD: Yes.

SENATOR BROUK: Okay. And what are the rates for that Medicaid reimbursement?

ACTING COMMISSIONER McDONALD: It's going to go to $1500.

SENATOR BROUK: Fifteen hundred dollars. And what does that include?

ACTING COMMISSIONER McDONALD: It's the doula care for the entire pregnancy and the postpartum period.

You know, it was $600; we had that pilot in Erie County and Kings County.

{Unintelligible} and nobody set up from Kings County, but we had about 50 doulas in Erie County. So this is a pretty substantial increase.

You know, one of the things I saw when I looked at the perinatal hearings that Chair Gottfried and Chair Paulin hosted November 30th of 2021 was several doulas testified, you know, they made really clear how important this was not just culturally, but how they save lives. And I totally agree with you. I mean, there's a fair amount of research that talks about the importance of doulas just saving lives.

And, you know, quite frankly, birth needs to be a celestial experience in New York.

SENATOR BROUK: Couldn't agree more.

ACTING COMMISSIONER McDONALD: One of the things I pulled out of the perinatal hearing is, it isn't.

And, you know, I just got back; I've been away for a long time. But quite frankly we need to improve not just birth outcomes,

which are very important to me, but just birth, period. Because one of the things I pulled out of the perinatal hearings was women felt controlled, they didn't feel respected, they didn't feel like they were able to make the decisions they need to make. That just shouldn't be the case.

And so --

SENATOR BROUK: A hundred percent agree with you.

ACTING COMMISSIONER McDONALD: And so I think a doula is a great idea.

SENATOR BROUK: Thank you. I'm going to take a few more seconds because I think you're absolutely right, and you took the words right out of my mouth. This can save lives, we see decreases in cesarean rates, we see decreases in length of labor.

The thing I want to urge you to continue to consider, though, is making sure that this is getting implemented as quickly as possible, and that you do consider higher rates. Because we do know that the $1900 rate is much closer to an equitable

reimbursement rate. Thank you.

ACTING COMMISSIONER McDONALD: Thank you for your feedback.

CHAIRWOMAN KRUEGER: Thank you.

Assembly. (Pause.)

ASSEMBLYWOMAN PAULIN: Oh, sorry, I'm not used to being in this role.

Assemblyman David Weprin, who has 10 minutes.

ASSEMBLYMAN WEPRIN: Thank you, Madam Chair. I'm going to direct my question to the commissioner of the Department of Financial Services, Superintendent Harris.

Superintendent Harris, long-term-care insurance premium rates have increased beyond what most New Yorkers can afford. These significant increases threaten to force these policyholders to cancel their policies that they have dutifully paid into for many years. What is the Department of Financial Services doing to ensure that long-term-care premiums stay affordable to policyholders?

DFS SUPERINTENDENT HARRIS: Absolutely. Thank you so much, Assemblyman,

for that question.

As you know, you and I have talked about long-term care on a couple of occasions. At the department, we are tasked with balancing rate increases and the impact on consumers with the safety and soundness of the institutions that we regulate. It's important that they have the money, that they can pay claims when they become due. But long-term care is a national problem. Just as we are seeing the rates increasing in New York, we see that all over the country, and consumers faced with this terrible decision of paying increased rates or accepting a decline in benefits.

So there's a couple of things that we have done and are doing at the Department of Financial Services. First, I have directed the team to do a historical lookback, both in New York and around the country, to examine the poor assumptions that have been made by regulators and industry in the past that led to poor pricing.

Many of these books of business suffer

from poor assumptions where people did not understand that people were going to live longer, they didn't understand what was going to happen to the cost of healthcare, they made bad assumptions about how people were going to get rid of policies and how long they would keep them. And again, this was something we saw nationwide.

But in my view, regulators and industry around the country -- including here in New York, unfortunately -- did not adjust the data quickly enough once they knew those assumptions were no good. And so I've directed the team to do a lookback and do an examination so that we can put some sunlight on this issue and hopefully make better decisions going forward.

The other thing that we're doing, as you know, is the Governor has put a health guarantee fund in the Executive Budget. New York is the only state in the country without a healthcare guarantee fund. And this is important with respect to long-term care because right now in New York, if you

have a constituent who buys a long-term-care policy through a life insurance company, we have a life guarantee fund. And if that company become insolvent, your constituent has the protection of that fund should that company become insolvent.

If that constituent were to buy the same policy through a healthcare insurer and that health insurer became insolvent, that constituent would have no protection. And to me, that's not a good public policy outcome.

So right now in New York is we're the only state without a healthcare guarantee fund. Obviously we work very hard at the department to make sure that entities remain safe and sound. But in the event that they don't or in the event -- we have a live example now where another state has moved to put a long-term-care company into liquidation, essentially forcing our hand here in New York. We want that fund in place to protect consumers.

ASSEMBLYMAN WEPRIN: Without disclosing any confidential information, is

there a fear in New York potentially of a company going insolvent?

DFS SUPERINTENDENT HARRIS: So we have one company where we've filed for rehabilitation last week. This was a company where the parent company is a Pennsylvania-based company. Pennsylvania moved to liquidate their company in 2017. Frankly, I think New York could have acted faster in liquidating or moving to rehabilitate the New York subsidiary. But we've moved it to rehabilitation now, and it will be up to the court how the rehabilitation or liquidation schedule moves forward.

That company has over 600 New Yorkers who are either paying for their policies -- there's about 70 New Yorkers who are currently on claim. And should the court move the company to liquidation before there's a health guarantee fund in place here in New York, those 70 New Yorker who are currently on claim would be forced to find care elsewhere. They'd literally be taken

out of their long-term-care facilities, losing the investment they have.

For those policyholders who are not currently on claim but have been paying in for decades and decades, they would effectively lose that investment. So that's why it's incredibly important that we have the health guarantee fund here in place in New York just like 49 other states do.

ASSEMBLYMAN WEPRIN: Okay. In the event a long-term-care underwriter becomes insolvent, what is the purpose of splitting assessments equally between health and life insurers when the latter write a majority of the LTC policies?

DFS SUPERINTENDENT HARRIS: The proposal that the Governor's put forward in the budget is based on the National Association of Insurance Commissioners model law. It is very close to what we see in every other state in the nation. Having a joint fund, a joint health and life guarantee fund, is what we see in that model. It's something that insurers are used to complying

with in 49 other states. And it prevents the state from having to stand up a completely separate administrative apparatus.

ASSEMBLYMAN WEPRIN: Is DFS concerned that this proposal could force the health insurance industry to subsidize long-term care policies of insolvent life insurers?

DFS SUPERINTENDENT HARRIS: Not at all, sir. In fact, to be clear, the guarantee funds support consumers. So they are not a bailout for companies. They are meant to support those consumers when a health insurance company becomes insolvent. The assessments are levied only in the event of an insolvency. They are levied proportionally to the amount of premiums that the companies write in the state. And again, this is something that insurers are used to complying with in every other state in the nation. So this should not be hard for them to administer or comply with.

ASSEMBLYMAN WEPRIN: Okay, thank you. I'm going to now turn to drug pricing.

Prescription drug prices have

increased significantly in recent years, increasing costs to consumers and the healthcare system at large. What accounts for these dramatic increases?

DFS SUPERINTENDENT HARRIS: Thank you so much for that question.

As you know, we have, thanks to the Legislature and the Governor, the ability to oversee pharmacy benefit managers now at DFS. We've built up an incredible team and we have registered all PBMs in the state. But there's still more work to do because the single biggest contributing cost to healthcare is the increase in prescription drug prices.

So what you see in the Governor's proposal is a five-part plan where we are requiring drug manufacturers to disclose ahead of time price increases to the state so that it helps policyholders make better choices when it comes to their healthcare.

We're also requiring, where the federal government has not acted, that pay-for-delay agreements are disclosed to the

department as well.

And then the proposal includes the provision for oversight of a number of entities along the prescription drug supply chain, including PSAOs, rebate aggregators, and switch companies. All of these are meant to add transparency along the prescription drug supply chain and hopefully help keep costs down for consumers.

ASSEMBLYMAN WEPRIN: Okay. And how does the Drug Accountability Board make drugs more affordable?

DFS SUPERINTENDENT HARRIS: The Drug Accountability Board is a wonderful tool we have at DFS where it permits us to investigate price spikes of 50 percent or more in one year. Obviously most price increases aren't that dramatic, which is why the disclosure provision in the Governor's proposal is so important.

But that -- the Drug Accountability Board, which includes your colleague Assemblymember McDonald, investigates those drug price spikes. We've concluded one

investigation to date where we found that essentially there was no price increase, but there were controls that were not up to par at the company, and we've now remediated those. But we have several investigations currently underway as well.

ASSEMBLYMAN WEPRIN: Okay. How would HMH Part Y -- you referred to it briefly, the Prescription Drug Price and Supply Chain Transparency Act of 2023 -- how would that contribute to these efforts?

DFS SUPERINTENDENT HARRIS: Again, it adds transparency. And I want to be mindful of my time because there are a lot of components to that. But certainly I mentioned the Drug Accountability Board has the ability to investigate large price spikes.

But often what we see is the majority of price increases are much smaller price spikes. So having manufacturers disclose those price increases in advance and incentivize them to disclose those price increases with as much time as possible is

going to be an important factor for us in help keeping prescription drug prices low.

And again, having pay-for-delay agreements disclosed and adding oversight to PSAOs, rebate aggregators, and switch companies -- all of which add costs and margin along the prescription drug supply chain -- will help us bring transparency to a very opaque market.

ASSEMBLYMAN WEPRIN: Okay. And my time is running out of my 10 minutes. But there's a similar bill in Oregon -- are you following that? -- requiring advance notification of drug prices in Oregon. And that's currently being challenged legally.

Does DFS have concerns regarding the potential for litigation on the disclosure and notification requirements included in your proposal? Or in our proposal.

DFS SUPERINTENDENT HARRIS: I am happy to respond to that in writing.

ASSEMBLYMAN WEPRIN: Okay.

CHAIRWOMAN KRUEGER: Maybe you should come back to us in writing about that.

DFS SUPERINTENDENT HARRIS: Yes, absolutely, happy to do so. Thank you.

CHAIRWOMAN KRUEGER: Thank you.

ASSEMBLYMAN WEPRIN: Thank you, Superintendent. Thank you, Madam Chair.

CHAIRWOMAN KRUEGER: So we've been joined by several additional Senators since last we named names. So Senator Salazar, Senator Sanders, Senator Hoylman-Sigal.

Do you have a list of additional Assemblymembers?

ASSEMBLYWOMAN PAULIN: I do. We've been joined by 4 González-Rojas, Rosenthal, Anderson, Sillitti, and Solages.

CHAIRWOMAN KRUEGER: Great, thank you.

And people will notice that a number of seats are no longer really available, so just a new rule of the hearings this year: The two chairs at the far ends, either side in the front row, they're designed that if somebody else needs to ask a question and they don't have a microphone, then whoever's sitting there needs to get up for them so they can use that seat.

But Michelle Hinchey, who's the next questioner, has already figured that out and is in that seat. Thank you.

SENATOR HINCHEY: Thank you very much. I've sat through one or two of these hearings in the last couple of weeks, so I've picked it up.

Thank you so much for being here. My question is for the acting commissioner. I represent four counties, and many of them are rural. And so a shared-service model is important -- specifically for one of them, I'll say that, Greene County, they don't have a local DOH, and so they're in the Oneonta region. And so that covers Otsego County, Delaware County, and Greene County. And I believe there are only about three inspectors for that entire region, for that entire department.

We had a business that was revitalizing -- helping to revitalize a community, putting in a business in a location that had been vacant for decades. And when they put in the application for

their Oneonta DOH, they were told that they would have to wait over a year to even get a response. Is that an appropriate amount of time for them to wait?

ACTING COMMISSIONER McDONALD: Well, no, it's not. So, I mean, this is the first I'm learning about this situation, though. And I'm happy to be helpful.

In other words, I really don't know about the staffing challenges there. I've met every local health department. But if you want to work with me offline, I can help out.

SENATOR HINCHEY: I will. I mean, we -- my office has talked with the Oneonta department at length, and it is -- doesn't seem to be getting any better. And of course I don't see any solutions in the budget for staffing, et cetera. So thank you, we will --

ACTING COMMISSIONER McDONALD: I mean, we do have -- just to add this. Like we do have the strengthening public health workforce grant coming, which is here. But

it's not part of the state budget, it's federal money, just so you know. This comes from the Centers for Disease Control and Prevention. It's $107 million, a five-year grant, but we get all the money up front.

Each local health department's getting at least $200,000, and then there's a multiple they get for population. So there might be help there, but this is where I'm happy to work offline, I really am.

SENATOR HINCHEY: Great, thank you. This is something that we need to solve. Of course they are then tasked with all of the businesses and parks, fairgrounds, everything -- which for a tourism community, that is everything they have. And so it's a major issue.

So happy to work with you. Thank you. We'll follow up, and I think they'll need some additional funding.

Secondly, New York State -- changing gears a little bit, New York State ranks last in hospice and palliative care. And this is something that's incredibly personal to me

and something that, you know, I believe all New Yorkers need to know more about.

I thank the Governor for signing our bill to raise awareness with a public information campaign. However, she did veto our bill to set up a director of hospice and palliative care.

And I want to know what are the plans within DOH to strengthen this so that New York is no longer last in this vital care sector?

ACTING COMMISSIONER McDONALD: Yeah, it saddens me that we might be last in hospice, because quite frankly hospice is very important. You know, when you think about just the sacred experience of passing, it's very important.

I don't know that in four seconds I can give you a detailed answer. How about I just get back to you on that one too, is that okay?

SENATOR HINCHEY: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Assembly.

ASSEMBLYWOMAN PAULIN: Yes, Assemblyman Jensen.

ASSEMBLYMAN JENSEN: Thank you very much, Madam Chair.

I am going to direct my questions to the DFS superintendent. But Commissioner McDonald, I am going to follow up with you by written correspondence. I'd love an opportunity to follow up in person or via written correspondence.

ACTING COMMISSIONER McDONALD: Yeah, please. Love to.

ASSEMBLYMAN JENSEN: Superintendent, I want to circle back to the health guarantee fund that the insurance chairman talked about. The proposed guarantee fund would impose two new classes of taxes on health plans, one for administrative costs and one to carry out the powers and duties of this association, based on 2 percent of premium revenue.

Who would be responsible for paying this new tax?

DFS SUPERINTENDENT HARRIS: Sir, I'm

not sure that that's part of the proposal, but I'm happy to circle back to you on that.

As I noted previously, the assessments are only levied if and when a company becomes insolvent. They are levied in proportion to the amount of premiums written by each company, so that smaller insurers will bear less of the assessment than the largest insurers.

And the way those assessments are then levied and the timing of the levying of the assessments is left up to the association, which is governed by industry representatives.

But I'm happy to come back to you on the tax and administrative issue.

ASSEMBLYMAN JENSEN: So whether it's -- you call it a tax or call it an assessment, the solvent insurers would be the ones left picking up the cost for the insolvent providers, correct?

DFS SUPERINTENDENT HARRIS: The solvent insurers then do provide the consumer protection for those New Yorkers who have

invested in their insurance and now are left without their investment due to the insolvent insurer.

And this is what we see in 49 other states.

ASSEMBLYMAN JENSEN: Okay. Unlike most other states, New York does have a large number of in-state not-for-profit health plans, especially in upstate, where I represent. Given that many of our large employers often self-insure and wouldn't be subject to this tax, slash, assessment, would these upstate small businesses and individuals be more disproportionately impacted by the 2 percent cost that would be levied to cover any insolvency elsewhere in the state?

DFS SUPERINTENDENT HARRIS: And again, I want to -- I want to make sure I'm stating that the assessment I think does not exceed 2 percent. So it is not a 2 percent assessment. That is the cap.

And again, it's levied proportionally due to size and premium written. And it is

up to the governing structure of the fund, which is again industry-led, to decide on the timing of the assessments and how they're levied.

And it's the model that we see throughout the country, everywhere but here in New York.

ASSEMBLYMAN JENSEN: Okay. The proposed budget includes a reauthorization of HCRA and related taxes on healthcare and health insurance. These fees, these taxes would next year reach about $6.4 billion, adding to the cost of health insurance.

Given this increase, which is still far out of sync with other states, do we really need to insure -- partnered with the oversight prerogatives of your department at DFS, do we really need to institute this type of guarantee fund, especially when we have very few providers, coverage providers, that are going insolvent?

DFS SUPERINTENDENT HARRIS: Absolutely. This coverage -- or this fund, this protection is necessary for New Yorkers.

New Yorkers are the only people in the country that do not have the protection of a health guarantee fund.

And again, as I mentioned, we have a live case currently where the department has filed for rehabilitation over 600 New Yorkers who have invested for decades in their long-term care, over 70 who are currently on claim and will be forced out of their long-term-care facilities, forced to try and find other policies -- which I can tell you they will not be able to do.

The average age of these constituents, by the way, is 82 years old. So they will be forced out of their long-term-care facilities. If they are to qualify for Medicaid, they'd have to spend down their assets, potentially, to be able to do so. Or they'd have to try and go out and find new policies. And on the off chance that they are able to find new policies, we're looking at an exponential increase in costs to them, despite the fact that they have invested for decades and decades to have the benefit that

they are currently enjoying.

And again, we've got the situation now where another state forced our hand by moving the parent company into liquidation. Those folks in Pennsylvania, just like consumers in New Jersey and Connecticut and all of our neighbors, have this protection -- and New Yorkers do not. And I don't think it's a good policy outcome for our constituents.

ASSEMBLYMAN JENSEN: So very quickly, with the institution of this fund as well as the other dramatic oversight that DFS has, do you currently have enough staff to fulfill all of the obligations that your department is tasked with?

DFS SUPERINTENDENT HARRIS: We are hiring and I'm happy to talk more about that with you offline.

ASSEMBLYMAN JENSEN: All right. Thank you, Superintendent.

DFS SUPERINTENDENT HARRIS: Thank you.

ASSEMBLYMAN JENSEN: Thank you, Madam Chair.

CHAIRWOMAN KRUEGER: Thank you.

Senator Gallivan, ranker on Health, for five minutes.

SENATOR GALLIVAN: Thank you, Madam Chair.

First, we've also been joined by Senator Borrello.

CHAIRWOMAN KRUEGER: And Senator Nathalia Fernandez. Thank you.

SENATOR GALLIVAN: Do I get my 8 seconds back?

CHAIRWOMAN KRUEGER: Yes.

(Laughter.)

SENATOR GALLIVAN: Good morning. Thank you all for your testimony. And thanks for your graciousness, Madam Chair.

My first two questions are directed to the Department of Health, whoever -- whichever you think is most appropriate to answer, please. They have to do with funding and programs.

The first one, last year the Legislature appropriated $800 million in the budget for hospitals that were disproportionately impacted by the pandemic,

by COVID-19, financially distressed because of that. To my knowledge, none of that money has gone out yet. And the concern is, how is it distributed, how are the decisions made? There's no metric that I know in statute that would define that.

And my question -- the question would be for that program, but also we have similar concerns about the VAPAP program, the Statewide Health Care Facility Transformation Program. And I know an announcement on that just went out in the last week or two. But the process, the metrics for any of those things, transparency related to it. Many of us have made calls, only to hear: Well, soon. Soon. Soon. Hospitals and nursing homes make those calls.

So the question, can you shed some light on the process and answer the question, do you think that we need statutory language that will define how these things are distributed as opposed to going into the Department of Health and waiting and waiting and waiting, and in the meantime our

hospitals and nursing homes are hurting.

MEDICAID DIRECTOR BASSIRI: I can take it.

ACTING COMMISSIONER McDONALD: Go ahead.

MEDICAID DIRECTOR BASSIRI: So thank you for the question, Senator.

There is a process. It is similar to how we distribute funding for the VAPAP program, which is a state-only Medicaid-funded program. And it's based on a case-by-case basis.

We work very closely with the financially distressed hospitals and nursing homes. We look at cash flows, we assess what their fiscal needs are throughout the year and prospectively, and based on their level of need to ensure they have enough cash flow and funding from the state, we determine what amount of funding we provide on an intermittent basis. It could be quarterly, it could be every other month. But there is a process, and it follows the process we've used historically to support financially

distressed hospitals and nursing homes.

SENATOR GALLIVAN: Time, of course, doesn't permit an extended conversation. That's hopefully something that we can follow up on.

MEDICAID DIRECTOR BASSIRI: Absolutely.

SENATOR GALLIVAN: But I think I can safely say that many of my colleagues have concerns about the process and the ultimate distribution and the fact that it takes so long.

The intercept of $625 million of FMAP, it creates a big hole for counties, upstate and New York City. How are counties going to fill that gap?

MEDICAID DIRECTOR BASSIRI: So I think we all are aware that in 2015 we capped the local share of the counties' Medicaid costs at about 7.6 billion. Since that time, we have grown the Medicaid program quite significantly, saving the counties I think $38 billion since 2015.

We have also taken over more of the

Medicaid administration than had previously been in place. You know, 83 percent of our enrollees are currently enrolled through the NY State of Health or will be redetermined through the NY State of Health, meaning there's less burden from Medicaid administration for the counties to absorb.

And they have received the enhanced federal funding that we've gotten since the COVID pandemic. So we believe that the countries have -- you know, they are getting the funding they need. We have absorbed, in the state, a significant portion of the growth in Medicaid. It's a $100 billion program now. In 2015 I can promise you it wasn't anywhere close to that.

A lot of that growth has been absorbed by the state and not the counties, and we're doing everything we can to reduce the burden for them as we go through the unwind and prospectively taking over all of Medicaid administration.

So we do believe they can absorb it. They have gotten other federal funding

outside of what the state has provided. And we think they can absorb the reduction.

SENATOR GALLIVAN: All right, thanks. Again, time doesn't permit an extended conversation. But we are going to hear from the counties later, so I would imagine there will be additional discussion --

MEDICAID DIRECTOR BASSIRI: Absolutely. And we are actively speaking with the county executives and the local commissioners.

SENATOR GALLIVAN: And Superintendent, without -- with only 14 seconds left, I'll follow up with questions with you later, if I may.

DFS SUPERINTENDENT HARRIS: Wonderful, thank you.

SENATOR GALLIVAN: Thank you all.

CHAIRWOMAN KRUEGER: Thank you.

Assembly.

ASSEMBLYWOMAN PAULIN: Assemblyman John McDonald, for three minutes.

ASSEMBLYMAN McDONALD: Thank you.

First of all, Superintendent, just

want to say thank you. The approach in regards to PBM regulation, the department's doing a wonderful job of --

DFS SUPERINTENDENT HARRIS: Thank you.

ASSEMBLYMAN McDONALD: -- making sure that everyone has an opportunity to participate. And just want to recognize that publicly.

My question is primarily for Amir in regards to NYRx, the pharmacy carveout. And I want to start off simply. Basically, the state is going back to the way we used to manage the drug benefit up until about 10 years ago, is that correct?

MEDICAID DIRECTOR BASSIRI: That is correct.

ASSEMBLYMAN McDONALD: So basically we're -- government is running its own drug program. Basically we're taking out the intermediaries, which is the pharmacy -- or the health plans and the PBMs, correct?

MEDICAID DIRECTOR BASSIRI: A hundred percent, yes. We are cutting out the PBMs from the Medicaid pharmacy business.

ASSEMBLYMAN McDONALD: So how many recipients do we have on Medicaid?

MEDICAID DIRECTOR BASSIRI: Right now we have 7.8 million.

ASSEMBLYMAN McDONALD: And as you know, there's a lot of sensitivity on my part, yours and many others about the impact on 340B entities. How many patients does that involve?

MEDICAID DIRECTOR BASSIRI: In terms of unique patients utilizing 340B or filing a 340B scrip, it's 250,000.

ASSEMBLYMAN McDONALD: Two hundred fifty thousand out of 8 million.

MEDICAID DIRECTOR BASSIRI: Correct.

ASSEMBLYMAN McDONALD: And on the 340B component, we're only talking about people who have straight Medicaid, not hospital-administered services, not people on Medicaid Part D, which is not something the state picks up, correct?

MEDICAID DIRECTOR BASSIRI: That is correct.

ASSEMBLYMAN McDONALD: So we're

talking about about 3 percent of the population of the State of New York for Medicaid recipients.

MEDICAID DIRECTOR BASSIRI: Yes.

ASSEMBLYMAN McDONALD: Okay. All right. So I guess, interestingly enough, if you were a fan of single-payer, wouldn't you really want NYRx to go forward?

MEDICAID DIRECTOR BASSIRI: Absolutely. That's exactly what it is, for one benefit. But if we were to do single-payer, that would be -- NYRx would be what provided the pharmacy benefit for all Medicaid members.

ASSEMBLYMAN McDONALD: The reason why I ask this is that I hear -- I still practice pharmacy regularly, so I hear from doctors, nurse practitioners, PAs regularly about all the formulary exclusions on these plans. And I've seen it with HIV meds, I've seen it with hep C meds, I've seen extensive prior authorizations, I've seen diabetes meds -- 50 percent of the time, there's prior authorizations and delays in care.

What is NYRx going to be doing to avoid that circumstance?

MEDICAID DIRECTOR BASSIRI: NYRx covers 100 percent of FDA-approved drugs. Every drug is covered. We do have a preferred drug list, so instead of the 12 or 13 managed-care-plan formularies, we'll have one. It's established. It's authorized by the Drug Utilization Review Board.

But when we compare formularies by therapeutic class, we see far better coverage than is currently available in managed care for those populations that use HIV, diabetes -- the MCO coverage on their formularies, on average, is 64 percent for diabetes medications. It is 100 percent on NYRx.

ASSEMBLYMAN McDONALD: Thank you.

MEDICAID DIRECTOR BASSIRI: Prior authorizations approve 50 percent without any prescriber intervention, 100 percent within 24 hours.

ASSEMBLYMAN McDONALD: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Senator May.

SENATOR MAY: Thank you.

Dr. McDonald, I want to ask a couple of quick local questions and then I have a bigger question for you.

So on local questions, I represent the Owasco Lake Watershed. I met with your environmental health team about finally getting an answer for the watershed rules and regulations that their association has put together, and they promised me, in about three months, an answer. Can you commit to the timeline?

ACTING COMMISSIONER McDONALD: Yes.

SENATOR MAY: All right. Okay. That's all I --

ACTING COMMISSIONER McDONALD: I'm very familiar with what's going on in Lake Owasco with the harmful algal blooms. Gary Ginsburg and I talk more than you possibly imagine about this. But yeah.

SENATOR MAY: Okay. Now my other question, local question, is about the Onondaga Nation. I represent the Onondaga

Nation. The state has binding treaty obligations to multiple tribal nations and has failed to fund their local health clinics at a level that enables them to actually hire doctors and nurses. So they've had to close on a weekly basis, and people are going to emergency rooms instead of getting primary care.

So I wonder what the department's commitment is to tribal health. Will you support adding the funds for the Onondaga, Tuscarora and Tonawanda clinics in the 30-day amendments? And how are we going to meet those treaty obligations?

ACTING COMMISSIONER McDONALD: Yeah, so any health service clinics are very near and dear to me. I actually worked in Chinle, Arizona, for two years plus, in the heart of the Navajo Nation. So I know the value of an Indian health service clinic, not just medically but culturally.

SENATOR MAY: Okay.

ACTING COMMISSIONER McDONALD: So I just learned about this last night, by the

way, what's going on in Onondaga --

SENATOR MAY: Okay, so maybe we can talk offline about it.

ACTING COMMISSIONER McDONALD: I'm saddened by this. I'm deeply saddened by this. I'm a friend. I will do what I can to be helpful.

SENATOR MAY: Great. Wonderful. And then my last question, as the lead sponsor of Fair Pay for Home Care, I am deeply concerned that the money isn't getting to the providers so that they can then pay the home care workers for the rise in minimum wage. DOH keeps telling us it's a matter of negotiation between the MLTC and the providers, but the providers say there is no negotiating, they just get a rate and are told take it or leave it.

So is DOH going to do more oversight on this? And can we have a talk about this offline and really try to solve this problem? We put a lot of money into increasing the number of home care workers out there, and it's having the opposite effect.

MEDICAID DIRECTOR BASSIRI: We can certainly talk about this offline, Senator.

I will just say I think you can see from the budget that we are not thrilled with health plans, including managed long term care plans. And by -- some of the other actions that we're taking are intended to ensure that any money we provide for home care gets to the provider and ultimately, you know, the worker.

SENATOR MAY: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Assembly.

ASSEMBLYWOMAN PAULIN: Yes.

Assemblyman Blumencranz.

ASSEMBLYMAN BLUMENCRANZ: Thank you so much.

Commissioner McDonald, could you please explain the policy rationale and intended effects of the Governor's proposal regarding Certificate of Need requirements to investor-owned entities, including physician practices?

ACTING COMMISSIONER McDONALD: Yeah,

so the short answer of it is it's trying to have some oversight where we don't have oversight. And it's modeled after what went on in Oregon.

You know, it's one of those things where if Amazon's going to come in and own something, we'd like to have a say in what's going on and just see what's going on.

ASSEMBLYMAN BLUMENCRANZ: Okay, thank you.

And then, Superintendent Harris, thank you for coming today. I want to piggyback off of what Chair Weprin -- his concerns surrounding long-term care. I was wondering, with your expertise as superintendent relating to long-term care, what would -- what legislative tools and solutions would you recommend for us to implement to help you in the process of lowering these increases that are continuing to plague our elderly and those who have paid for many years?

DFS SUPERINTENDENT HARRIS: Well, I think, not to sound like a broken record, but I do think that the health guarantee fund,

because so many of these books are written and the risks are what they are -- and the state of these carriers around the country is fairly precarious. So having that consumer protection in place in New York is going to be incredibly important.

I think going forward, as I mentioned, I've asked my team to do a thorough study of how decisions have been made over the past many decades, where assumptions were incorrect, why regulators and industry across the country were slow to fix them. And I expect that that research will produce any number of insights, many of which we will likely need you and your colleagues' help with implementing.

ASSEMBLYMAN BLUMENCRANZ: Thank you very much.

DFS SUPERINTENDENT HARRIS: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Senator Helming, ranker on Insurance, for five minutes.

SENATOR HELMING: Thank you, Senator Krueger.

Thank you for the testimony this morning. (Pause for mic.) Is that better?

SEVERAL PARTICIPANTS: Yes.

SENATOR HELMING: A couple of questions. First of all, I wanted to start with the 340B messaging that we heard this morning. I strongly, strongly agree with the messaging -- not the actions, but the messaging. My rural communities are served by the FQHCs. Without them, the delivery of medical services, mental health services, dental services to residents, to the migrant workers, will be severely impacted. So I hope that will be something that we will be taking a look at.

Real quick, Dr. McDonald, you had mentioned in the budget the various investments to emergency medical services statewide, which I truly appreciate, representing a rural district. It's incredible the need that exists.

And you may be aware -- if not, I want to make you aware -- that in 2021 the Legislature realized the significance of the

problems that we are experiencing, and the Governor signed into law legislation creating the Rural Ambulance Task Force. Again, that was signed into law at the end of 2021.

In 2022, it is tremendously disturbing to me that that task force was never convened. I understand that they have met once in 2023. The report is due back to the Legislature at the end of this year, December of 2023.

I'm hoping that you will be looking for the information, the recommendations, and that will help guide some of this funding. So --

ACTING COMMISSIONER McDONALD: Absolutely. You know, so I'll look for the report. You know, I just took over as commissioner January 1st, so I'm getting a list of all the mandated reports, finding out where they are and getting them back. And I want them back to you on time. That's the Navy officer in me that's used to doing that, quite frankly. So we'll see if we can get that done for you. Thank you.

SENATOR HELMING: I'd appreciate it.

Superintendent Harris, it's great to see you again. I wanted to switch gears and talk about the pay-and-resolve proposal that's in the budget. It's my understanding that New York's existing external review law, it's been a model that's been used by many states across the country, and in fact a model that's been used by the federal government.

And would you agree that the existing law resolves disputes between hospitals and plans by having an independent third party determine, in a short time frame, whether the claim was medically necessary?

DFS SUPERINTENDENT HARRIS: Yes, I think that's an accurate statement.

SENATOR HELMING: Then I'm wondering why the department feels that this pay-and-resolve proposal is necessary in the context of the budget.

DFS SUPERINTENDENT HARRIS: Well, the pay-and-resolve proposal is limited to instances of emergency admission where

medical necessity is not in question. And it is meant or intended to help increase efficiency for those payments in the case of emergency admissions.

SENATOR HELMING: So are you saying that presently there are slowdowns with the payments, payments aren't being made in a timely manner under those circumstances?

DFS SUPERINTENDENT HARRIS: I think -- we have requirements for the timely payment for medical necessity currently in law, as you noted. This proposal is narrow and limited to emergency admissions and I think a good way to test if this will increase efficiencies even more.

SENATOR HELMING: Okay. Another question on the proposal. Many of our upstate hospitals have cooperative plans with the health plans that either offer monetary advances to hospitals to aid with cash flow and/or accelerated-payment agreements that expedite payments.

It seems to me, based on everything I've heard, that these agreements are working

quite well. Wouldn't this bill replace those agreements?

DFS SUPERINTENDENT HARRIS: In the narrow circumstance of the emergency admission. But I can confirm and come back to you.

SENATOR HELMING: Okay. Thank you. I guess I'm still -- it seems to me that the current process is working effectively.

I received correspondence indicating that DFS data from the first quarter of 2022 shows that health plans received 104 million claims, and denials related to medical necessity accounted for less than 1 percent of all claims. So again, I'm wondering why we're trying to fix something that it doesn't seem is broken.

And I only have a couple of seconds; I'll just wrap up by saying this. When I read the proposal set in the budget, ultimately I'm thinking about our constituents, our consumers. And I see proposals like the 340B that are going to take away services to the most vulnerable

populations. And I see proposals like this one and some others that ultimately will increase, drive up costs to consumers.

So I'm looking for changes in the 30-day budget amendments in the final budget.

Thank you.

DFS SUPERINTENDENT HARRIS: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Assembly.

ASSEMBLYWOMAN PAULIN: Assemblyman Gandolfo.

ASSEMBLYMAN GANDOLFO: Thank you, Madam Chair.

And thank you all for being here today.

My question is going to be directed at the acting commissioner. I want to ask about non-emergency medical transportation and the statewide broker RFP.

In the summer of 2022, a billion-dollar RFP was awarded to Medical Answering Services. That's a company that has no experience providing transportation in capitated or at-risk arrangement. The RFP

was awarded prior to an actuarial analysis of the bid cost, meaning the department had no idea whether the rate submitted by MAS could even be achieved.

On top of that, the owner of MAS donated hundreds of thousands to the Governor. And further, he held a fundraiser for the Governor at his house during the RFP blackout process, which would be a blatant violation of state finance procurement law. The department has now awarded a billion-dollar monopoly contract to an operator that may have engaged in pay-to-play with the Governor's office.

So I have two questions. Did the Governor or her office interfere with the RFP process? Do you have any knowledge of that?

MEDICAID DIRECTOR BASSIRI: Thank you for the question, Assemblymember. No, they did not.

ASSEMBLYMAN GANDOLFO: And do you have any concerns about placing every Medicaid member in a statewide broker that has no experience doing this work?

MEDICAID DIRECTOR BASSIRI: No, we do not. There are currently -- we have a transportation management. There are two or three transportation managers throughout the state. MAS and this vendor has significant experience supporting the Medicaid program. And we're moving to a broker model, which is an innovative model that we believe that they will have no issues implementing.

ASSEMBLYMAN GANDOLFO: So do you feel that you should look to carve out the managed-long-term-care population to ensure that other brokers do remain in the state, to avoid a monopoly?

MEDICAID DIRECTOR BASSIRI: Can you repeat that question, please?

ASSEMBLYMAN GANDOLFO: Should you look to carve out the managed-long-term-care population to ensure that other brokers do remain in the state?

MEDICAID DIRECTOR BASSIRI: We are phasing that in. It's sort of Phase 2 of the procurement. So we're first going to start with the non-MLTC population. And then

Phase 2, which will be the following year, would include those counties.

ASSEMBLYMAN GANDOLFO: Okay. Thank you very much.

CHAIRWOMAN KRUEGER: Thank you.

Senator John Liu.

SENATOR LIU: Thank you, Madam Chair.

And thanks to the commissioners for joining us today.

I only have three minutes, so I'd like to ask Superintendent Harris, how are we doing with the commuter vans? Has any progress been made?

DFS SUPERINTENDENT HARRIS: Thank you so much, Senator, for that question. As we've talked about on many occasions, this is an important transportation issue that's requiring a whole-of-government approach. It's a 30-year problem that nobody ever moved to address until last year. And thanks to you and your colleagues, we have the subsidy in the budget.

The RFP is live. ESD put that out, and it is live. And I don't have a status

update for you on the respondents to the RFP, but I believe it closes next month, and I'm very happy to keep you updated.

SENATOR LIU: Well, you've got a very long litany of accomplishments that you've provided us with in your testimony, both oral and written. But there's no mention of this. So I guess it's too small a matter for DFS to deal with?

DFS SUPERINTENDENT HARRIS: Not at all. It's an incredibly important transportation --

SENATOR LIU: DFS, its inattention to this matter -- because I'm hearing from your response that nothing's been done. It's been over a year since we put this thing in place, and you're still telling me that the RFP is out.

DFS SUPERINTENDENT HARRIS: The RFP was put out by ESD. Of course, as the regulator of insurance, we cannot solicit insurance to participate in this program. So it was with ESD to put out the RFP, and it is now out --

SENATOR LIU: Whoever it's with, it's a DFS issue, isn't it?

DFS SUPERINTENDENT HARRIS: No, it is an incredibly important transportation issue. We come at it through the narrow lens of insurance.

And again, it's an issue that's been in place since the nineties, and nobody did anything about it until you and your colleagues looked closely to get it done last year.

SENATOR LIU: All right. Well, I understand that. We talked about this even in your confirmation hearing, that you said you would take the -- make it a high priority to fix. Because you were a fixer, you were a doer. And a year has transpired, and DFS -- this is not a problem that you created, but you certainly inherited it. You pledged to fix it. And DFS continues to be the single biggest driver behind causing failure of the commuter van industry, which thousands of our constituents rely upon.

So when are you going to get it done?

Or have you just given up? Because it's not mentioned in any of your reporting. You cite a litany of successes that your leadership has engendered at DFS, but no -- not even a mention of the commuter vans.

DFS SUPERINTENDENT HARRIS: Again, I believe it's an incredibly important transportation issue. It's something we address through the --

SENATOR LIU: Not important enough for you to mention.

DFS SUPERINTENDENT HARRIS: One that we address through the narrow lens of insurance. It's something that MTA, TLC, ESD and many others have a part to play in --

SENATOR LIU: But it is an insurance issue. It's the insurance issue, plain and simple, that's driving these commuter vans out of business and therefore our constituents being deprived of badly needed transportation services.

DFS SUPERINTENDENT HARRIS: And as you know, sir, the commuter vans generate $1.50 in claims for every dollar of premium. That

subsidy that you all put in place will help with that tremendously. And we're looking forward to implementing the program.

SENATOR LIU: Let's get some progress done. Thank you.

CHAIRWOMAN KRUEGER: Senator Liu -- I'm sorry, your time is up. Just in case you might not have been here in the beginning, and for everyone else who got here late, the commissioner is here only to answer health insurance questions today.

Her agency covers an enormous number of issues that many of us have concerns about. And I'm sure she will follow up with you, since you used your time to go down this line of questioning. But again, the deal for today, the topic being health, was the questions should be specific to health insurance. Thank you.

SENATOR LIU: Thank you, Madam Chair.

CHAIRWOMAN KRUEGER: And Assembly.

ASSEMBLYWOMAN PAULIN: Assemblyman Bronson.

ASSEMBLYMAN BRONSON: Thank you,

Madam Chair.

I'm going to try to get two questions in. So the first is for the Medicaid director. But if we could keep it at a minute and a half, because we're not going to resolve this issue about 340B.

But I've got to tell you, when those protestors walked into this room and they had the -- from the early ages of HIV and AIDS -- t-shirts on with the pink triangle, which I have on the back of my car, every car I've ever owned since the '80s, that said "Silence=Death" -- I don't care if we're talking only about 250,000 people out of 8 million. These are 250,000 lives.

And we know that in HIV you have to stay on your regimen so that it is a controllable illness. We also know that if you're on that regimen that you -- oftentimes you're undetectable, and that prevents us from transmitting the virus to another person, helping us with our goal of ending the epidemic.

Yet the 340B carveout schedule for

April 1st will eliminate the services necessary to help people stay on their regimen, such as nutrition, housing, mental health, other services that they absolutely need.

How can you guarantee that the CMS is going to get the approvals in and that we're ready to go April 1st and that the funding is going to be there year in and year out? How can you guarantee that with this change?

MEDICAID DIRECTOR BASSIRI: So I can guarantee that we are ready. We've been ready for the last three and a half years operationally in terms of implementing the transition. And as -- I don't know who mentioned it earlier, we did have this responsibility for 4 million Medicaid members pre-2012.

That said, the hospital reinvestment, the 5 percent, we did a 1 percent trend last year, so we know we're going to get a federal match on that. We've been in active and ongoing conversations with the federal government on the clinic FQHC investment.

They understand the timeline. We are working behind the scenes to cut through administrative tape when we submit the state plan.

But a state plan amendment that builds this reinvestment into our agreement with the federal government is as permanent as it gets in the Medicaid program. This is not funding we intend to take back. We are paying back every dollar that the health centers have quoted to give that they need. And we fully intend to give that to them, knowing that today that funding is being diverted by some intermediaries in the process.

So I would love to talk about this with you when we have more time, Assemblymember. But I will personally guarantee that there will not be a reduction in services through the health centers, because there can't be if they're going to get more money than they get today.

ASSEMBLYMAN BRONSON: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Senator Ashby.

SENATOR ASHBY: Thank you, Madam Chair.

Director Bassiri, regarding the eFMAP funds, do you believe it's the intention of the federal government for these funds to be shared with our local governments? Based off your previous response --

MEDICAID DIRECTOR BASSIRI: Do I believe that it is the federal government's intent? I think the federal government's intent is that the local share be capped at what it was in 2015 for Medicaid.

SENATOR ASHBY: So the funds that we're currently getting, you don't believe that they should go to our local governments.

MEDICAID DIRECTOR BASSIRI: No, I think they are going to our local governments.

I think the argument is that, you know, should they go to our local governments indefinitely at the same rate they were, you know, eight years ago, when the program has grown significantly and the state has absorbed that cost. I think that's a

different discussion.

SENATOR ASHBY: Okay.

Dr. McDonald, where will the new psychiatric beds under Article 28 be located? And do you have a time frame?

ACTING COMMISSIONER McDONALD: Yeah, we did send a letter with Dr. Sullivan, Office of Mental Health. It's a work in progress right now. We're still assessing what's there. As soon as the time {inaudible} business strategy -- I don't want to quote it wrong, but it's obviously something we know is important.

It's important to have mental health capacity and to have the psychiatric beds online. There's some obstacles that need to be overcome that we understand. But we're working as quick we can to move in that direction.

SENATOR ASHBY: Do you have a time frame in mind?

ACTING COMMISSIONER McDONALD: I don't have a time frame in mind. I'll get back to you with that.

SENATOR ASHBY: Okay. I appreciate it.

And Superintendent Harris, regarding the site of service review, do you have any data to support diverting patients away from ambulatory surgical centers?

DFS SUPERINTENDENT HARRIS: So what the site of service proposal is intended to do is (A) make people disclose their site-of-service policies as well as make sure that we're prioritizing patient access, choice, and continuity of care.

SENATOR ASHBY: It just seems to me that, you know, there's no financial association with this policy. What's the rationale for it being included in the budget?

DFS SUPERINTENDENT HARRIS: That's feedback I'm happy to take back to the executive chamber.

SENATOR ASHBY: I'd appreciate it. Because I know that my constituents and I know throughout New York State a lot of people rely on these settings for the

procedures. And, you know, the staffing shortages that we've had, it's -- they're essential to have. And so it would be great to see that data, and I appreciate -- appreciate your response.

And Director Bassiri, going back to the eFMAP, it seems as though the counties really are being excluded. I mean, you may say that in other ways they are getting the funding, but I think that we're going to hear testimony today -- and with the county officials that I've spoken to throughout my district, they're asserting that they are being completely excluded from funding that they have been expecting.

What's your response to that?

MEDICAID DIRECTOR BASSIRI: I can certainly understand where the counties are coming from.

I will say that the Executive and the department is willing to work with the counties through the budget process to ensure there's no disruption in their budgets.

SENATOR ASHBY: I appreciate it.

Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Assembly.

ASSEMBLYWOMAN PAULIN: Assemblymember Rosenthal.

ASSEMBLYWOMAN ROSENTHAL: Okay. Thank you, Chair Paulin, Chair Krueger.

My question is for Medicaid Director Bassiri.

Last year we collectively took action to ensure that home care workers are compensated appropriately for their work, ensuring that home care workers earn $3 above the regional minimum wage. And this was below the fair pay proposal the home care industry needs, and ones that I and many others were active in. Home care workers deserve more money. But it was a step in the right direction.

In this year's Executive Budget, however, the Governor's minimum-wage proposal breaks that promise by freezing home care wages, eventually returning home care wages to the minimum wage. If enacted, this home

care shortage, which we all know about, will worsen.

So does the Department of Health believe home care workers should be paid the minimum wage?

MEDICAID DIRECTOR BASSIRI: Thank you for the question, Assemblymember Rosenthal.

No, we believe they should be paid higher than the minimum wage, which is the Governor's position as well, you know, as evidenced by last year's investment for home care worker wages. It was a $3 increase above the $15 minimum wage. We've done two of those dollars, and we will be doing the other dollar in October of this coming year.

It's important to remember that the -- what we actually put into law and what we established is that the minimum wage for home care workers is higher than the minimum wage for non-home care workers. We did not put into place a requirement that everybody get a $3 or $2 increase.

ASSEMBLYWOMAN ROSENTHAL: Well, the budget returns home care workers to the

minimum wage, though, even as data makes clear the only solution to the home care worker shortage is raising their wages.

So can you just say yes or no if home care workers should be paid minimum wage?

MEDICAID DIRECTOR BASSIRI: They are not going to -- that -- you're referring to the inflation, the minimum-wage inflation that the Governor put in the budget this year, and that it excludes home care workers. And I was saying earlier that that change in payment is not going to happen until 2029, 2030.

ASSEMBLYWOMAN ROSENTHAL: Can you explain why?

MEDICAID DIRECTOR BASSIRI: Because the CPI, what we've been seeing based on the projections that we're looking at for CPI as compared to the minimum wage, will not exceed $18 until 2029 or 2030.

ASSEMBLYWOMAN ROSENTHAL: Okay. I mean, you're certainly aware of the shortage in home care workers, in nursing, in the

whole field -- but in particular, the home care workers who help people stay at home.

MEDICAID DIRECTOR BASSIRI: Absolutely. Absolutely. I don't disagree with that at all.

I would just say, in addition to the minimum wage, we have made investments in the direct care workforce through the American Rescue Plan Act of an additional $2 billion.

ASSEMBLYWOMAN ROSENTHAL: Well, that expires. That's a one-time.

MEDICAID DIRECTOR BASSIRI: But those funds are meant to support the direct care workforce. And we will continue making investments in the direct care workforce. We recognize the need of home care workers.

ASSEMBLYWOMAN ROSENTHAL: Okay, thank you.

CHAIRWOMAN KRUEGER: Great. Senator -- I'm sorry, I lost track of my list. Senator Sanders.

(Off the record.)

CHAIRWOMAN KRUEGER: When somebody needs to testify, they go to the far end,

either chair, and borrow that. Thank you.

SENATOR SANDERS: Thank you to the chairs. Good to see you all.

Good to see you, Superintendent. I just want to start by thanking you for the very good relationship that we have established where we're getting a lot of stuff done. And although this is not the time nor the place to speak of it, I look forward to when we have the time and the place to speak of the economic necessities that we are building together.

So let me turn to -- you spoke of a fund, a health fund that only New York State -- New York State is the only state that doesn't have this. Why is that? Why -- I mean, how did we end up here?

DFS SUPERINTENDENT HARRIS: Thank you, Senator Sanders. I too enjoy our wonderful working relationship, and I thank you for that.

I cannot speak to why it is that New York is the only state in the nation without a health guarantee fund. I can only

tell you that I believe that it's incredibly important for consumer protection to put in place now, especially as we have a live case with a long-term-care insurer that we have moved to put into rehabilitation. And I think it would be a crying shame if those 600-plus New Yorkers were left without the benefits they've invested in over many decades.

So I look forward to working with you and your colleagues to hopefully get this proposal through.

SENATOR SANDERS: As America ages -- and New York is no exception -- this becomes even more important.

Have we figured out how much would it cost to bankroll such a fund?

DFS SUPERINTENDENT HARRIS: Thank you, sir. It's actually not a cost to taxpayers. These funds, just like the property and casualty fund, we have a life insurance fund -- what we've put forward here is consistent with the National Association of Insurance Commissioners' model.

The funds to support the consumers, the policyholders of the insurance company that becomes insolvent, come from other insurance companies. So I will tell you in the present case that we're dealing with at DFS, we expect that when those assessments are levied on other companies in the insurance space, if there is a health guarantee fund in place, it would be on average about $10,000 a year per insurer to make sure that over 600 New Yorkers have the care that they've invested in over decades.

SENATOR SANDERS: That does sound doable.

Does the -- how does the industry feel about this, the insurance industry feel about this?

DFS SUPERINTENDENT HARRIS: I would let them speak for themselves. But I would say that they comply with such requirements in these funds in 49 other states, so it should not be a hard lift to do so here.

SENATOR SANDERS: Thank you, Madam Superintendent.

Thank you to the chairs.

CHAIRWOMAN KRUEGER: Thank you.

Assembly.

ASSEMBLYWOMAN PAULIN: Yes.

Assemblymember Kelles.

ASSEMBLYWOMAN KELLES: Wonderful.

Thank you so much all for being here.

So I have a question about the state giving insurance plans funding that was meant for home care. So my assessment -- I'll just read from the notes that I have written. Last year's budget included nearly a billion dollars to fund the $3-an-hour wage increase -- we've all been talking about it -- yet nearly all of the managed care plans failed to pass this amount, we've talked about this, on to the agencies. And as a result, home care agencies do not have sufficient funding to pay worker wages and meet their own costs.

Forty-three percent of surveyed home care agencies are declining new cases, the data shows, and 17 percent are seriously considering closing down. These are the data

that we're getting.

So there was a Times Union article that reported private insurance companies are offering pay bumps as low as 20 cents and 50 cents per hour, according to offers from two insurance companies. So that's the data we're getting. It seems a bit contrary.

So I have an analysis that shows the state's 25 managed care plans kept 722 million in profits in 2021. That's three-quarters of a billion dollars. Should DOH continue to give private insurance companies three-quarters of a billion dollars meant for home care workers?

MEDICAID DIRECTOR BASSIRI: Thank you for the question, Assemblymember.

I don't know what you're referring to with the 700 million in profits. But what we -- we do have a medical loss ratio in place; that medical loss ratio is 86 percent, meaning that the health plans have to spend 86 percent of their premium on medical services, which includes personal care hours and wages. We are increasing that percentage

to 89 this year.

ASSEMBLYWOMAN KELLES: We do have that percentage. But the audits were not done for a very long time. Last year was the first time an audit was done. And there was a clawback of over $200 million, from my understanding.

Is that audit going to continue every year from now on?

MEDICAID DIRECTOR BASSIRI: I think what you may be referring to is a COVID risk -- during the 2020-'21 period we had a COVID risk corridor, where we took money back from the health plans. And that is what I believe you're referring to.

ASSEMBLYWOMAN KELLES: No, I'm referring to --

MEDICAID DIRECTOR BASSIRI: I'm happy to take this offline.

ASSEMBLYWOMAN KELLES: -- that they weren't actually passing on the percentage that they were supposed to be passing on. So we were supposed to be auditing them every year. And we did an audit, as far as I know,

last year.

MEDICAID DIRECTOR BASSIRI: We do audit their cost reports every year. We audit their financials every year.

What I would say is the only way it's possible that a worker did not get an increase or got a 20 cent increase is if they were already making $17 or $18 an hour. So there were some workers who were getting less than that, they were getting 15. They should be getting the full 2-plus dollars per hour.

ASSEMBLYWOMAN KELLES: So that will be part of your audit, then, to make sure they're getting the $3 when you do the additional dollar.

MEDICAID DIRECTOR BASSIRI: We are going to be doing more policing with the Office of the Medicaid Inspector General to ensure that any additional dollars get to the worker.

But I just want to reiterate, though, that --

ASSEMBLYWOMAN KELLES: I just wanted to add to what --

MEDICAID DIRECTOR BASSIRI: -- we raised the minimum wage. We raised the minimum wage.

ASSEMBLYWOMAN KELLES: Right. But that it will be held to minimum wage by 2029.

ASSEMBLYWOMAN PAULIN: Thank you.

ASSEMBLYWOMAN KELLES: Just adding my voice to everyone else's. Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Senator Rhoads.

SENATOR RHOADS: Thank you, Chairwoman.

With only three minutes, I had no intention of making this comment. But I just wanted to say, to Director Bassiri, taking away 20 percent from the counties is going to lead directly to property tax increases. There's no other way around it. You look at Nassau County, for example, every single dollar that Nassau County collects in property taxes goes to fund Medicare -- goes to fund Medicaid. Every dollar. And that's not the only county.

And for the Governor to come in and

express, through you, her position that she gets to spend not only the state's federal COVID money but gets to spend the counties' federal COVID money, is disgraceful.

So I wish you would consider that, because it will lead directly to property tax increases.

With respect to Superintendent Harris, just on pay and pursue -- and again, we're limited by time. I fail to understand -- and Senator Helming did a wonderful job questioning in limited time. But I fail to understand how a process that takes three months to resolve will be improved by replacing it with a process that takes, according to your own timeline, 10 to 14 months.

DFS SUPERINTENDENT HARRIS: Sir, I'm not --

SENATOR RHOADS: How does that -- how does that aid consumers in any way?

DFS SUPERINTENDENT HARRIS: You're referring to the appeals process, is that --

SENATOR RHOADS: Yes.

DFS SUPERINTENDENT HARRIS: What I can tell you is that the pay-and-resolve proposal that the Governor's put forward is limited to these emergency admissions, where medical necessity is not in question and therefore we don't expect there to be appeals because the medical necessity question is effectively answered by virtue of the fact that these are emergency admissions.

SENATOR RHOADS: But whether it's an emergency admission or a regular admission, why is a 10-to-14-month time frame to get a resolution to whether it was medically necessary more advantageous than a process that takes 90 days?

DFS SUPERINTENDENT HARRIS: It would not be.

SENATOR RHOADS: So why are we doing this?

DFS SUPERINTENDENT HARRIS: I'm happy to take that feedback back. But as I noted, this is just a narrow -- narrow proposal limited to emergency admissions.

SENATOR RHOADS: So it's a bad idea

that would affect a limited number? Is that what we're saying?

DFS SUPERINTENDENT HARRIS: I'm happy to take your feedback back, Senator.

SENATOR RHOADS: And just one other quick question.

With respect to the health insurance guarantee fund, your department already has review power for life insurers that issue health insurance companies under Article 77. Section 307 of the Insurance Law requires all insurers to file annual statements with DFS. Section 309 of the Insurance Law permits DFS to make an examination into the affairs of any insurer.

Section 1322 of the Insurance Law requires all health insurers to submit a risk-based capital RBC report, right? So you get to review their formulas. Section 4310 of the Insurance Law prescribes minimum statutory reserve fund requirements. Section 308 of the Insurance Law confers carte blanche power to the superintendent to conduct an inquiry into any transaction.

Why is it now, given all the regulatory authority you have, that now we need to have a health guarantee insurance fund?

DFS SUPERINTENDENT HARRIS: Sometimes our hand is forced by other states, as in the current case.

CHAIRWOMAN KRUEGER: Thank you very much.

Assembly.

ASSEMBLYWOMAN PAULIN: Assemblymember Alex Bores.

ASSEMBLYMAN BORES: Thank you.

A few weeks ago Commissioner Bray joined us from DHS and said that preventing future pandemics was one of the focuses of DHS, and most of the investment in the budget was actually through the Health Department and related fields.

Would just love if you could talk a little bit about the investment being made to prevent future pandemics and to manage risks in the future.

ACTING COMMISSIONER McDONALD: Yeah,

so what we're working on right now is staffing up our epidemiology department. one of the things that, you know, we have to look at when you look at pandemics, most likely one's going to be an infectious disease pandemic. So our epidemiology department is strong, but it needed to be stronger. So we're increasing staffing in that area.

Another division we're creating in 2023 -- excuse me, in the '24 budget, is a vaccine division. Really trying to get some more just work in the vaccine space. The vaccine space has changed so much. And it's just amazing how much disinformation and misinformation is out there. One of the things we've really seen is just purposeful misinformation.

Which we just need a stronger skill set at the department to understand why it's happening, where it's happening, and what is the sensible way to address it. Because, quite frankly, I've been a pediatrician well over 30 years. The --

ASSEMBLYMAN BORES: If you don't mind,

could I just interrupt?

ACTING COMMISSIONER McDONALD: Go ahead.

ASSEMBLYMAN BORES: Is that what the Division of Vaccine Excellence is going to do.

ACTING COMMISSIONER McDONALD: Yes. It's -- the Division of Vaccine Excellence is going to help us improve our vaccine rates for all vaccines in our state. But quite frankly, also, we're going to address, you know, quite frankly, pandemic vaccines as well.

But, you know -- and I just want to make this point. I've been a pediatrician well over 30 years. We have never had safer vaccines, yet I've never had a more challenging time in the exam room convincing parents to take these extremely safe, lovely vaccines.

So it's one of those things where we just need to find better tools to talk to our public about it. Because as a physician I care very deeply about the public, but I

don't want to be twisting arms. What I've been doing is saying, Look, I've got something great for you, I want you to want it.

One of the things I noticed, by the way, when I worked on the Navajo reservation, it was never an issue --

ASSEMBLYMAN BORES: You mind if I just -- I have a minute left. I want to make sure to get one other question in.

ACTING COMMISSIONER McDONALD: Sorry.

ASSEMBLYMAN BORES: But I appreciate the passion around this quite a bit.

ACTING COMMISSIONER McDONALD: Just to let you know I'm there for you.

ASSEMBLYMAN BORES: Thank you.

You mentioned sort of interstate compacts earlier around nursing and around doctors. I want to talk about a different one, which is around data sharing around norovirus.

Fourteen states currently opt in to monitor norovirus and share data with the CDC. New York is not one of them, despite

recent reports that New York City might be becoming a hotbed for it. Would just love your thoughts about that sort of data sharing with the feds and how we can help monitor for potential viruses and pandemics.

ACTING COMMISSIONER McDONALD: Yes. So norovirus, just so people know, is something that causes the stomach flu. If you've had vomiting, diarrhea recently, you can thank norovirus for that. It's miserable. It's spread by touch. Hand sanitizer and soap and water work well.

I was not aware that we're not part of a data-sharing agreement with other states. My general approach is to share data where possible, especially with the federals. But I'd like to do it in a way that makes sense. So let me see what's possible. In other words, I'll get into the issue, look at it, and get back to you.

ASSEMBLYMAN BORES: Wonderful. Thank you.

ACTING COMMISSIONER McDONALD: Sure.

CHAIRWOMAN KRUEGER: Thank you.

Senator Webb.

SENATOR WEBB: Good morning.

So I have a few questions, so -- to Commissioner McDonald.

The Governor's Executive Budget includes an increase to reproductive and sexual healthcare services. My question is, does this increase include abortion care, both procedural and medication? And if it does not include all abortion care, please explain why.

ACTING COMMISSIONER McDONALD: Well, let me just say, really quick, yes, it does increase -- particularly for surgical abortions, there's a 30 percent increase. But Director Bassiri, you might have additional detail.

MEDICAID DIRECTOR BASSIRI: Commissioner McDonald is correct, there's a 30 percent increase proposed for surgical abortion procedures. We are also going to require that health plans reimburse no less than that higher rate and issue some new standards for the providers.

It does not include increases for the medication abortion treatment medications. The reason is because we have current state law that requires us to reimburse those medications at acquisition cost. It will be available for anyone in the state that needs them. But to bundle it with the other services was not necessary because we currently have them available as separate billable services.

SENATOR WEBB: I will definitely be talking with you further about that, because it should be combined.

And so my next question goes to non-emergency Medicaid transportation. In my district we have a lot of issues as it relates to having access to transportation. And so I'm concerned that in the Governor's budget it does not include support for non-emergency Medicaid transportation.

So my question is, what is the department doing to ensure that providers continue to serve in transportation deserts?

MEDICAID DIRECTOR BASSIRI: We've done

a number of things throughout the year, with rising inflation and cost of labor, to offer some relief to NEMT transportation providers.

But we were very focused in this year's budget on the emergency transportation and some of the issues we were seeing there. But we have a range of different administrative things we've done to support NEMT providers, from gas relief to additional funding for labor, things of that nature.

Be happy to follow up after.

SENATOR WEBB: Yes, because one of the things that was raised to me is that it was -- the main issue is the reimbursement rates with this particular service, and it's having a serious impact on Medicaid recipients who actually rely on this service.

So with the time I have left -- and I'll follow up with Superintendent Harris. One of the things that gets a lot of attention is our efforts in the state to reduce our carbon footprint and also engage in other practices that help us get clean air. One of the questions I have relates

to -- there's an issue with your office, and I'm trying to understand why your office is preventing what's called liability risk -- excuse me, risk retention groups from being able to be licensed to do business in our state. And New York is the only state in the country that's creating this challenge.

So I would like to talk with you offline about that.

DFS SUPERINTENDENT HARRIS: Happy to do so.

SENATOR WEBB: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Assembly.

ASSEMBLYWOMAN PAULIN: Yes, Assemblymember Solages.

ASSEMBLYWOMAN SOLAGES: Thank you, commissioners.

You know, as you know, New York State's safety-net hospitals serve a large population, people of color, underserved, underinsured, who otherwise might not seek medical attention. And we see that this Executive Budget leaves a lot unsaid.

So what specific initiatives and strategies is the department implementing to support and strengthen safety-net hospitals in New York State?

ACTING COMMISSIONER McDONALD: So, you know, we did just release quite a bit of money through Statewide III that included safety-net hospitals, and I believe the number was $341 million included in that. There is a lot more money in Statewide IV. It's a total of 1.6 billion. But safety-net hospitals -- you know, we have a process for that that's objective and fair. You know, and we have 1 billion planned in this budget for Statewide V as well.

You know, I think safety-net hospitals need help too with labor, quite frankly. Travel nurses is something that we need to -- you know, in the budget is just asking for transparency from travel nurse companies. You know, one of the things I hear from hospitals is the need to understand their costs, be able to predict their costs. And labor costs is a big issue for them as well.

I do think interstate licensure compacts will help every hospital in the state, including safety-nets, quite frankly. You know, this is something that -- 37 states have done the nursing compact, 37 states have done the physician compact. I think it's long since time for New York to do this.

ASSEMBLYWOMAN SOLAGES: Okay. I know another fundamental problem driving the crisis is the current Medicaid coverage gap. And so right now Medicaid only covers 65 percent of the cost of services. How do you expect hospitals to, you know, survive under this? And do you believe that the Medicaid reimbursement rate should be at least 10 percent?

MEDICAID DIRECTOR BASSIRI: So, happy to take that question, Assemblymember.

Medicaid reimbursement on the inpatient side, that -- I think you're referring to fee for service, right?

ASSEMBLYWOMAN SOLAGES: Yes.

MEDICAID DIRECTOR BASSIRI: So for the safety net hospitals, and especially in the

last couple of years, we've actually taken a different strategy, working with the federal government to do something called a directed payment, which tells the managed care plans they have to pay that hospital a specific reimbursement rate. Those rates are significantly higher.

ASSEMBLYWOMAN SOLAGES: And then we're -- we're just having a larger conversation about housing. The proposal, you know -- when we're talking about, you know, lead and removing lead and lead poisoning in our properties, the current proposal doesn't meet the 2019 requirements to protect children under the age of 6.

So what more can the state do to ensure that we're complying with this 2019 law?

ACTING COMMISSIONER McDONALD: So I actually think the lead proposal in this budget is historic. We're talking about 24 municipalities in the state's highest-risk -- 80 percent of our cases.

One of the things I love about this,

we're actually checking the property instead of the child. What we've been doing for decades, many other states as well, is to wait for the child's elevated lead level and then go look at the property. It's high time we stopped using children to indicate there's a problem. So I think this is a very important thing for New York State.

The bipartisan infrastructure bill, though, for replacing lead service lines, that's real. That's $150 million every year for five years.

ASSEMBLYWOMAN SOLAGES: So when do we get --

ACTING COMMISSIONER McDONALD: I think, you know, when we get to the bottom of it, we might be able to --

ASSEMBLYWOMAN SOLAGES: When do we get to implementing -- we'll talk offline. But I appreciate it. Thank you.

ACTING COMMISSIONER McDONALD: I'd love to. Yeah, I want to help. Thank you.

ASSEMBLYWOMAN PAULIN: Senator Borrello.

SENATOR BORRELLO: Yes, thank you.

For the Medicaid director. Sir, you had mentioned that obviously the state needs to catch up on the funds because it capped the funds at the county level. Can you tell me, with one in three New Yorkers on Medicaid, who sets the guidelines and the parameters for who is eligible to get Medicaid? Is it the state or the county governments?

MEDICAID DIRECTOR BASSIRI: It begins with the federal government, then it's the state.

SENATOR BORRELLO: So the state and the federal but not the county.

So with that being said, you know, with -- what other states besides New York still saddle county governments, local governments with a local share of Medicaid?

MEDICAID DIRECTOR BASSIRI: I don't have that offhand. There are a handful, and different states structure their county relationships differently. But we can get back to you with that information.

SENATOR BORRELLO: Well, I spent 10 years in county government, and I believe New York is one of the last ones.

But -- so my question is, if New York State controls who's eligible and what benefits they receive -- New York State's the most generous, I believe, of all the states, as far as those Medicaid benefits -- then how is it we justify taking federal money away from counties to fill that gap?

MEDICAID DIRECTOR BASSIRI: I don't necessarily think that's the way we are justifying it.

There are things the state has done to expand Medicaid coverage and benefits and services. We've absorbed all of that cost. All of the growth since 2015 has been absorbed by the state.

SENATOR BORRELLO: But the state also set those parameters.

Does any other state have one in three of their residents on Medicaid, any other state besides New York?

MEDICAID DIRECTOR BASSIRI: I think

California may.

But in any event, what I was also going to say is since the PHE in March 2020, the counties really have not had any responsibility with respect to Medicaid eligibility or administration. So for the last three years they have not had to change -- or dedicate any resources towards Medicaid administration. They've actually repurposed those staff to deal with other county needs while the state has reimbursed their Medicaid admin at the current rate that we pay.

During that time we've taken over a lot more of the Medicaid administration than had been previously in place, and I think those are important considerations.

SENATOR BORRELLO: Well, yeah, but yet it's still the largest line item for every county government.

And you say that they've not taken over responsibility. They also have no say.

Would you be in favor of county governments being able to determine, each

individual county, what Medicaid benefits they give to the residents that ask for that? I mean, I think that would be a great solution, wouldn't you think? If the counties want to --

MEDICAID DIRECTOR BASSIRI: They do have a role in some of the long-term care determinations and eligibility. Counties employ nurses that do the assessments and --

SENATOR BORRELLO: Well, it's very limited.

I'm asking you a very specific question: Would you be in favor of having county governments determine which Medicaid programs they offer in their counties, as a way to stem the cost of Medicaid?

MEDICAID DIRECTOR BASSIRI: No, I would not.

SENATOR BORRELLO: Okay. So then why are we taking money away from the federal government that the federal government intended for counties when clearly New York State government is completely in control of what this program looks like and who's

eligible for it.

MEDICAID DIRECTOR BASSIRI: All I would say is that there's multiple funding streams, including multiple federal funding streams. Not all of those streams are being taken from the counties. There are funding streams that we've received from the federal government that will continue to be paid to the counties.

ASSEMBLYWOMAN PAULIN: Thank you both. Thank you.

SENATOR BORRELLO: Thank you.

ASSEMBLYWOMAN PAULIN: Assemblymember Lunsford.

ASSEMBLYWOMAN LUNSFORD: Thank you very much.

This first question is probably best suited to the Medicaid director, but feel free to hop in if you have an opinion.

Seventy percent of our nursing home beds are covered by Medicaid, and right now our nursing homes are running roughly a 165 to over $200 a day gap in those reimbursement rates. In Monroe County alone, in that

region, we have about a thousand beds offline right now. There's a 5 percent Medicaid rate increase recommended in the Executive Budget.

Do you think that's a sufficient amount of money to help close that gap and bring those beds back online?

MEDICAID DIRECTOR BASSIRI: I think the investment is a step in the right direction. It's the largest investment we've made for nursing homes since I can remember, I think --

ASSEMBLYWOMAN LUNSFORD: Fifteen years.

MEDICAID DIRECTOR BASSIRI: -- 15, 20 years.

I will also say we've done other things to support nursing home workforce. We have a health workforce bonus program. We've spent 1.5 billion; I think 300 million has gone directly to nursing homes to support staff. We have 1.5 billion allocated in our 1115 waiver for financially distressed hospitals and nursing homes.

There is a strong commitment from the

state and the Governor to support nursing homes through the transition.

ASSEMBLYWOMAN LUNSFORD: What I'm hearing from our providers is that 5 percent is not only insufficient to bring those beds back online but to even maintain our nursing homes at their current rates.

This is a critical time where some of my nursing homes are saying that they're not going to be able to survive the year. We've already lost a long-time high-performing not-for-profit nursing home because they couldn't meet these needs. So I'm just going to suggest that 5 percent is insufficient.

But I'd like to switch, while I have a minute and a half, to the acting commissioner. Early Intervention services right now are suffering a tremendous wait time. We have a provider shortage. We've had kids in Monroe County age out of Early Intervention services while waiting to receive them.

I don't see an increase in the rate in the budget. What are you suggesting we do to

address this crisis?

ACTING COMMISSIONER McDONALD: Well, Early Intervention's very important. I can tell you it's important for kids birth to 3, and it's a safety net for a lot of kids. You know, I can tell you as a pediatrician I've seen countless children just be helped by Early Intervention. I think it's just a wonderful thing to see how kids get back on the path.

So, you know, I'm concerned about the delays we have in New York State. You know, there was a rate increase in '19 for occupational therapists, speech therapists and physical therapists. There was the 1 percent increase last year. You know, we have to look at what our options are, quite frankly.

I mean, I'd love to have more conversation with you about that, because you might be able to tell I'm a big fan of Early Intervention, right? As a pediatrician, I see it and I see how it works.

ASSEMBLYWOMAN LUNSFORD: It's certainly a cost-saver in the long-term.

ACTING COMMISSIONER McDONALD: It really is.

ASSEMBLYWOMAN LUNSFORD: So I would support looking at maybe a rate increase to help address that. Right now too many of our kids are receiving some of these services, like speech and PT and OT through telemedicine, which is really not an adequate replacement when you are dealing with those kinds of issues.

ACTING COMMISSIONER McDONALD: Yeah, I'm a big fan of telemedicine, but for kids in particular, that space, it's hard. And, I mean, there's the county share with Early Intervention -- it's complicated.

But I want to keep more conversation going on this, please.

ASSEMBLYWOMAN LUNSFORD: Thank you. I appreciate it.

ASSEMBLYWOMAN PAULIN: Senator Thomas.

SENATOR THOMAS: Hi. Thanks for being here to testify. I've got three questions,

and the first is for the superintendent.

You know, Superintendent Harris, you and I have been working hand in hand on a number of issues consumer-related. I've heard from providers in my district that DFS has been slow to respond to complaints that providers are filing about insurance companies.

What can the Legislature do to help DFS respond to requests sooner?

DFS SUPERINTENDENT HARRIS: Thank you so much for that question, Senator.

Earlier I noted that in 2022, DFS returned $151 million directly to New Yorkers in the form of restitution. It was double the prior year, something I'm very proud of.

I have some numbers right here. Last year we had about 56,000 complaints and external appeals. We currently have 42 staff that staff our Consumer Assistance Unit. So I think the main thing that the Legislature could do to assist us is to help us staff up and make sure that we have the room in our FTE and budget allocations to do that.

Just because I like math so much, if you take that number, 42, and divide it by the 151 million, and you assume on average those Consumer Assistance Unit workers are making $100,000 for a round number, they are returning $3.6 million to New Yorkers for a $100,000 investment. That is assessed on our regulated entities and is not a cost to taxpayers.

SENATOR THOMAS: So more money for --

DFS SUPERINTENDENT HARRIS: More money, more FTEs, more staff, yes.

SENATOR THOMAS: All right. My second question here is another complaint about insurance companies. Hospitals are complaining that insurance companies keep denying claims without human review. You have these algorithms and AI that, you know, just keep denying claims, and hospitals are hit with the bill.

What can the Legislature do to stop this? What are the agencies doing as well?

That's for everyone.

DFS SUPERINTENDENT HARRIS: I'm happy

to jump in.

We were chatting, actually, earlier about the low number of incorrect denials and the efficacy of the appeals process. I think it's something that the team at DFS does very well. But again, it's an issue where more staff could help the timeline and the efficacy of the reviews.

I do think the majority of denials don't come from commercial plans, however, so I would defer to my colleagues.

MEDICAID DIRECTOR BASSIRI: Well, what I would say to that, what we're doing -- because we have seen an increasing number of denials specifically for the safety-net hospitals from the insurers.

So with some of our funding strategies for distressed hospitals, I referred to a directed payment template earlier. We're actually doing something even further than that. It's called separate payment terms, which essentially only pays the insurers what they pay the hospitals in terms of the premium. So it really eliminates the

incentive for a denial and ensures that the hospital is being paid appropriately.

SENATOR THOMAS: All right. I have one last question, but I have three seconds left. It's about Nassau University Medical Center. But I guess I will talk to Dr. McDonald later on about that.

Thank you.

ASSEMBLYWOMAN PAULIN: Thank you.

Next is Assemblymember González-Rojas.

ASSEMBLYWOMAN GONZÁLEZ-ROJAS: Thank you so much. I have a very simple question for the interim commissioner.

Dr. McDonald, does this administration care about the health of immigrant New Yorkers?

ACTING COMMISSIONER McDONALD: I'm sorry, I didn't hear the question.

ASSEMBLYWOMAN GONZÁLEZ-ROJAS: Does the administration care about the health of immigrant New Yorkers?

ACTING COMMISSIONER McDONALD: Yes, very much so. You know, it's a very important issue, quite frankly. I mean, yes,

healthcare is a basic human right, you know, and I don't think I'm covering any news when I'm saying that here. You know, the undocumented issue in particular, it's something we've been looking at, either as a fair amount of financial uncertainty that we just have to keep looking at.

I know -- we talked about this quite a bit. Let me just ask Medicaid Director Bassiri to chime in a little bit too --

ASSEMBLYWOMAN GONZÁLEZ-ROJAS: Yes. Yes, because I know where you're -- you know where I'm going with this. I want to speak specifically about the opportunity for New York State to submit a federal waiver, called a 1332 waiver -- yes, thank you -- to ensure and expand coverage for undocumented communities through the Essential Plan.

So maybe the -- Mr. Bassiri --

MEDICAID DIRECTOR BASSIRI: Yes, thank you for the question.

And we have looked at this and explored the opportunity. And, you know, currently we believe that there's just too

much uncertainty to go forward with the expansion of undocumented in -- through that waiver. And I'll give you some reasons why.

When we -- as we've gone through the process and looked more at it, we cannot utilize the Essential Plan trust fund as a source of revenue.

ASSEMBLYWOMAN GONZÁLEZ-ROJAS: Why not?

MEDICAID DIRECTOR BASSIRI: Because it's tied to 1331 federal law, which authorizes the Basic Health Program. This is a program outside of 1331. It's going to 1332. And so you can't use the funds that are dedicated for 1331 on that population, which is ineligible for that product.

That said --

ASSEMBLYWOMAN GONZÁLEZ-ROJAS: Is it because of federal policy? Why is that?

MEDICAID DIRECTOR BASSIRI: It is a federal policy. They are willing to provide what we are calling pass-through funds or the annual surplus we generate from the Essential Plan and the people covered in it.

It's roughly, I think -- it's around $2 billion a year. It's unclear in terms of our enrollment estimates that we will be able to support the number of potential enrollees that would take up the program --

ASSEMBLYWOMAN GONZÁLEZ-ROJAS: We anticipate 245,000 people that would benefit from this.

MEDICAID DIRECTOR BASSIRI: And I think that is beyond the allotment we would have through the pass-through funding under this opportunity.

ASSEMBLYWOMAN GONZÁLEZ-ROJAS: Why might we not try and submit the waiver?

MEDICAID DIRECTOR BASSIRI: I'm happy to take that back. And I complete -- I appreciate your question and think everyone at this table is supportive of expanding coverage for all populations.

ASSEMBLYWOMAN GONZÁLEZ-ROJAS: There's -- we're currently in a comment period to do so, and we have gone partially through that 30 days; I think there's been over 300 comments, many in support of

extending that for our undocumented community members.

So I would love to have you on record saying that you would assess those comments and look at amending that waiver.

MEDICAID DIRECTOR BASSIRI: We absolutely will assess those comments and take the feedback as required under the rules.

ASSEMBLYWOMAN GONZÁLEZ-ROJAS: Thank you.

ASSEMBLYWOMAN PAULIN: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Health Chair Gustavo Rivera.

SENATOR RIVERA: Batting cleanup. We're going to pick up right there. All right. Let's actually keep going down that rabbit hole, folks.

Colorado and Washington did this. We're saying we can't. Why not, again?

MEDICAID DIRECTOR BASSIRI: Good to see you, Senator. So --

(Laughter.)

SENATOR RIVERA: Good to see you too,

buddy.

MEDICAID DIRECTOR BASSIRI: Yeah. Colorado and Washington did something like this. So Colorado and Washington were able to get approval to offer subsidized individual health insurance to undocumented members. It is not nearly what I think is being proposed in --

SENATOR RIVERA: Could we use an Essential Plan look-alike?

MEDICAID DIRECTOR BASSIRI: It could be possible.

I just want you to understand that the Colorado and Washington models are very different than what has been proposed by the Legislature in the past and what we were -- what the Governor was seeking to partner with the federal government on, in terms of comprehensive coverage and no cost to the consumer.

SENATOR RIVERA: Gotcha, okay.

Last year we were able to get coverage for 65 and -- for 65-plus, as well as folks who are birthing people for up to a year.

And you're delaying it. So it kind of goes to the question that the Assemblymember asked you right off the bat. Is that a demonstration of your care for immigrant people?

MEDICAID DIRECTOR BASSIRI: I can say unequivocally that we are not walking away from what we agreed upon last year. We are 100 percent committed to covering the 65-plus population, as is the Governor.

We implemented a series of changes last year, coverage expansion changes. Many of them were set to take effect tomorrow. Expanding income eligibility for adults, eliminating Child Health Plus premium -- there's several changes we made. Many of those changes have to be made to three eligibility systems, including the ones that the local districts use.

As we went through this process, we realized we would be imposing a pretty significant burden on the counties by having this population enroll through the local districts, and we figured out a better way to

do it -- better for the consumer, better for the state -- by making some system changes to have them enroll through the New York State of Health.

SENATOR RIVERA: Gotcha, okay.

MEDICAID DIRECTOR BASSIRI: We need time to make those changes.

SENATOR RIVERA: I've got to -- since I have limited time. So we'll definitely follow up on that issue.

But one quick thing. How much do we spend on emergency Medicaid for this population right now, do you know?

MEDICAID DIRECTOR BASSIRI: For the entire population?

SENATOR RIVERA: For the population that will be covered by the expansion. It's roughly 500 million. So if we're talking about less than 500 million, it probably would be a good investment. Just saying.

Moving on, let's talk about 340B for a little bit. First of all, just -- and I know you know this already -- 5136. Look at the bill, 5136.

Now, there's many of my colleagues that have spoken about this. Assemblymember Bronson in particular underlined the fact that whether we're talking about 250,000 lives, as was mentioned earlier, as though it was a minor number -- and that's not your number, I gotcha. But it was kind of mentioned in that spirit. And I'm glad that we kind of pooh-poohed that. Not only do we certainly care about those 250,000 people, but also the broader issue is the -- that these savings actually allow these institutions to continue to exist and provide services for everybody, not just for the folks who benefit from the program. So it's a little bit kind of like, you know -- and again, it wasn't you, but I just wanted to get that for the record.

A question. You're talking about the permanence of how you're going to make these folks whole, right? Let's talk first about the amount that you're suggesting would go in this budget. How did you come up with that amount? Could you show us the math?

MEDICAID DIRECTOR BASSIRI: We can absolutely show you the math for each --

SENATOR RIVERA: You're sure you can.

MEDICAID DIRECTOR BASSIRI: -- every single provider.

SENATOR RIVERA: You're on the record, bro. You'll show me the math?

MEDICAID DIRECTOR BASSIRI: I'll show you the numbers. Love to show you the numbers.

SENATOR RIVERA: Please. Because you all know -- not you, but kind of -- I've been around here for long enough. And the administration, and Ms. Baldwin knows, they rarely show us the math. Everybody knows, you're going to show us the math. So number one.

Number two. As far as the permanence of this, you're talking about a state plan amendment, right? Would you agree that statute would be more permanent than a state plan amendment?

MEDICAID DIRECTOR BASSIRI: I think they're, in this context, probably

equivalent. But sure, yeah, statute is probably more permanent.

SENATOR RIVERA: Cool. That's why some of us are seeking something like -- that's statutory.

But anyway -- and you have thought about the operational challenges that SNPs might actually have from this?

MEDICAID DIRECTOR BASSIRI: We have. We're in conversations with the SNPs. We're going to take some of their requests to the federal government. At the end of the day, we're not taking any savings from the SNPs in terms of the administrative savings that we'll get from all the other health plans. And to the extent there is a shortfall, we have the funding to resolve it. It's very minor.

SENATOR RIVERA: I'm sure we're going to revisit that because we're not too sure about that either.

But moving on, let's talk about MLTCs.

Now, first of all, there's a whole bunch of reports that you folks have owed us

for a while. One of them is this one, that was supposed to be done October 31, 2022. You might -- are you going to tell me that it's in my email right now?

MEDICAID DIRECTOR BASSIRI: The interim report is in your email right now.

SENATOR RIVERA: Ahhh, I knew it. Because you all did some last night when you dropped like five or six reports that were due like months ago and we got them {snapping fingers} last night.

(Laughter.)

MEDICAID DIRECTOR BASSIRI: What I would say is --

SENATOR RIVERA: Photo finish.

So this one -- so there is a -- so there is a report, there is one in my email right now?

MEDICAID DIRECTOR BASSIRI: There is an interim report with the Legislature, yes.

SENATOR RIVERA: Beautiful. Okay. So I'm going to be looking at that. It would have been great to look at it before, maybe like between October 31st and now, but

regardless.

So there is -- there's a lot of concerns that we have about network adequacy. Right? And that's something also that crosses over with DFS. And so what steps are you folks -- are you taking to ensure network adequacy? And just give me something like --

MEDICAID DIRECTOR BASSIRI: So we are very interested in updating our network adequacy standards. We have been in discussions with the federal government and other states to see what's out there. We know that there will be new access standards put in place by CMS -- time standards, making sure people can get appointments in a timely basis, proximity, telehealth, et cetera.

We want to use the next year to do a quality incentive to get some baseline information, because our current standards do not allow us to quantify how plans are meeting those standards in an empirical, defined way. And so CMS is going to come out with the rules. We want to do a quality incentive next year and then make them

permanent in the following year.

SENATOR RIVERA: So at some point we will certainly, in a nontimed conversation, we'll have deep conversations about this. Because I have -- as you know, health plans -- (loudly) my favorite. And issues of network adequacy really concern me, and the way that they get around what is supposed to be a standard that already exists and how they are enforced by the Department of Health and DFS, certainly a concern about that.

Moving on, workforce. Now, there's -- you talked about some of the stuff that you've -- some of the challenges that you're having within the Health Department. We've talked about that before. But speaking about things that you -- that we created that -- you know, like reports that are supposed to come to us that don't. Last year we had the Office of Healthcare Workforce Innovation. We put 20 more million on it this year. That's phenomenal.

What is it actually doing?

ACTING COMMISSIONER McDONALD: Well,

it hasn't started yet. It's just starting out. We're just hiring people for it now. The director who's just being hired is on-boarded next month. So it's just starting.

SENATOR RIVERA: Gotcha. So even though we created it last year --

ACTING COMMISSIONER McDONALD: I'm just telling you what I know. We're on-boarding a director next month.

SENATOR RIVERA: Hoo hoo hoo hoo. Moving on. Let's do -- and hospital funding. There's a couple of questions certainly I would -- what Senator Myrie asked about related to safety-net institutions, obviously I care deeply about safety net institutions. Let me ask a technical question.

It's my understanding that that DPT, direct payment template program, is still pending CMS approval. Could you tell us the status of that, please?

MEDICAID DIRECTOR BASSIRI: We have those approved. We recently got those approved for '22 and '23.

SENATOR RIVERA: Like today too?

MEDICAID DIRECTOR BASSIRI: No, it was --

SENATOR RIVERA: Is that also in my email?

MEDICAID DIRECTOR BASSIRI: I don't have the exact date, but it was about mid-January.

SENATOR RIVERA: Okay. All right. Now, there was also -- and as far as reports, getting them -- like last night we got the ambulette rate report. That was last night. Thank you so much for that.

MEDICAID DIRECTOR BASSIRI: It was a busy night.

(Laughter.)

SENATOR RIVERA: There's a question -- Senator May and a couple of folks asked this question related to home care and related to the $3. Now, there is definitely a lot of -- it just seems that you folks are kind of -- kind of playing with terminology here.

First of all, there are serious concerns -- and I know you've heard them,

because you've heard them from me, you've heard them from providers, you've heard them from workers themselves. We approved the 2 and the 3. We approved it here, but it's not what is getting to workers. That's just reality. And it's being kept by, again, the folks who are (loudly) my favorite. Right?

So my question is, how do we actually make sure that this does not happen in the future? Right? And can you assure me -- I mean, we should just ask more questions about whether the -- I'm going to have a second round because there's one last one that I want to ask. But I'm going to leave the last 45 seconds to you to tell us.

So is this -- is this MLTC thing -- why are we sticking with it? Why? Can you tell me that?

MEDICAID DIRECTOR BASSIRI: I think we've made significant -- you know, New York has a long history in managed care, and especially with provider-sponsored health plans running managed care.

We do believe in MLTC for the benefits

it has in duals integration, individuals that are covered and get their benefits from Medicaid and Medicare in -- under one plan, ideally.

Getting rid of MLTC, you know, it certainly would help ensure that the dollars that we make available for home care go to the providers. I don't know that it guarantees that the providers get those dollars to the workers. There are benefits from care coordination that we get in MLTC that we do not have in fee for service. This is not pharmacy. There are -- there are a lot of care management functions necessary to do MLTC. And we do believe in that model, with reform.

SENATOR RIVERA: I will have more. Thank you.

ASSEMBLYWOMAN PAULIN: Assemblymember Byrnes.

ASSEMBLYWOMAN BYRNES: Thank you.

I have a couple of quick questions. The first will be for Mr. McDonald, the second I believe will be for Ms. Harris. And

I'll ask them both at the same time.
Ms. Harris, that gives you a heads-up for a second to think about your answer.

Look, in the Governor's Executive Budget there's a proposal for $1 billion for the fifth version of the Health Care Facility Transformation Program. Just now, or recently, the winners of Version III were just announced, and there seems to be a significant divide between money allocated upstate and downstate. Just by way of one example, in the Finger Lakes region, which I represent -- home to over 1.2 million people -- they've received 21 million in Round III. Westchester County alone, home of 1 million people -- less -- received $70 million in Round III.

My question is, clearly there's a great difference between money allocated to one smaller county than to my entire region, with more people. If Version V, with $1 billion, is allowed, how is that money going to be distributed to the benefit of all New Yorkers? Because, sir, as you said in

your opening statement, you stressed healthcare equity for the benefit of all New Yorkers is what you wanted. How is this money going to be distributed to benefit all New Yorkers, including upstaters?

And then the next question, for Ms. Harris, will be how -- in nursing homes, how much of the distressed provider funds have actually -- for nursing homes have actually been disbursed?

Commissioner?

ACTING COMMISSIONER McDONALD: Yeah, thank you so much.

So, you know, there is a process for Statewide III. There's a process for Statewide IV. I think the best thing for me to do is just send you this objective process. The Statewide IV, which is happening now, is 1.6 billion. In this budget the Statewide V, which is 1 billion -- you know, I'll just send you the process and then you can see it's an objective process. I think it's fair. There's no intention, of course, to favor one part of the state over

another part of the state. I mean, we want to be fair to everyone in the state.

You're absolutely right, health equity matters for all New Yorkers all the time. And it's very deeply important to me. My whole career has been about finding health equity everywhere I've gone.

Let me now just turn it now to the superintendent.

ASSEMBLYWOMAN BYRNES: But when our constituents look at something, it shows that 70 million is going to an area with less people than the Finger Lakes region, which tends to be more rural, upstate. Yet we're all paying taxes, the same amount of taxes. We all are deserving of healthcare equity. How can you justify this disparity? And how do you ensure, most importantly, that it doesn't happen again?

DFS SUPERINTENDENT HARRIS: If I may, Assemblywoman. We do look at the percentage of awards that come in, and make awards based on that.

And I would just call out that we are

rolling out awards now, we just announced another $200 million this morning, of which 50 million went to the Finger Lakes region.

So we are looking at this holistically in the way in which we make our awards. They come out in phases. And we'll continue to look at the awards to make sure they're equitable across the state.

ASSEMBLYWOMAN BYRNES: Ms. Harris, I know you're going to have to answer me later.

Thank you.

DFS SUPERINTENDENT HARRIS: Thank you.

ASSEMBLYWOMAN BYRNES: Unless the chair allows.

CHAIRWOMAN KRUEGER: Thank you.

Assembly? Okay, thank you. I think I'm the last Senator for Round 1. Thank you.

Okay, start with reproductive health funding. So there was a commitment of additional Medicaid funding for community-based health centers. And reproductive health centers would fall under that? I'm confused about this.

MEDICAID DIRECTOR BASSIRI: I think

you may be referring to some capital or grant funding at Department of Health now?

CHAIRWOMAN KRUEGER: No, Medicaid reimbursement rates.

MEDICAID DIRECTOR BASSIRI: No? referring to -- we're actually increasing the reimbursement rate for surgical abortion procedures.

CHAIRWOMAN KRUEGER: So there's not an across-the-board Medicaid reimbursement increase for the kinds of health services community-based health centers provide, which is most Planned Parenthoods.

MEDICAID DIRECTOR BASSIRI: There would be for family planning. There would be for family planning services as well. I think those are 30 percent as well; I will confirm that for you.

But -- and then we're requiring health plans to benchmark to no less than those higher fee-for-service reimbursement rates.

CHAIRWOMAN KRUEGER: Okay. But so Medicaid is doing a higher --

MEDICAID DIRECTOR BASSIRI: Yes.

CHAIRWOMAN KRUEGER: -- reimbursement rate across the board for services they provide.

MEDICAID DIRECTOR BASSIRI: Correct.

CHAIRWOMAN KRUEGER: So then second question, of the complaint that the level of reimbursement for specific abortion services is way too low. And so there was I think additional money for surgical abortions but not for medical abortions. Is that correct?

MEDICAID DIRECTOR BASSIRI: That is correct. Thirty percent increase.

CHAIRWOMAN KRUEGER: Thirty percent --

MEDICAID DIRECTOR BASSIRI: -- increase above the current $1,000 reimbursement. So it's going to 1300.

CHAIRWOMAN KRUEGER: So a medical abortion, though, would be a service provided by the health center, whoever they are. So would they be eligible for the increased Medicaid reimbursement for those services?

MEDICAID DIRECTOR BASSIRI: I would want to confirm and get back to you so I don't give you the wrong information. But my

assumption is yes.

CHAIRWOMAN KRUEGER: So you think yes, but you're going to get back to me with confirmation. Thank you. That's helpful.

Actually for DFS, following up on a variation on a question my colleague Gustavo Rivera just asked about the networks -- well, he asked the question, I think, of the Department of Health on the network coverage of inadequate doctors in a network, and that's mostly for the Medicaid population. But there's a huge number of people on private insurance, and I get complaints constantly that the networks their insurance companies -- which I think are under you -- are negotiating with and that there's a real inadequacy of actual providers.

One, are you tracking that? What are you learning? And what can we do about it? Because I know that it's a problem.

DFS SUPERINTENDENT HARRIS: Absolutely. Thank you, Senator.

We abide by the network adequacy standards set by DOH. And as you noted, the

networks are -- under Insurance Law, are required to be adequate. So we assess the data from the insurers to help ensure that that is in fact the case.

Where we have a consumer that cannot get the service they need in-network, the insurance company is required to let them go to an out-of-network provider at in-network cost. And that's one thing we do to help ensure network adequacy.

Also, as you know, we finalized a regulation last year that held consumers harmless for insurance company misinformation. So where an insurance company tells a consumer that somebody is in-network and it turns out that they are out of network, this regulation now holds the consumer harmless and makes the insurance company responsible for that misinformation.

CHAIRWOMAN KRUEGER: Okay. So I think we have to do a better job of letting the consumers know that if they can't find a doctor to go to in their network and their provider -- their insurance provider isn't

doing anything about that, that they have the right to go to out-of-network, but for the same cost.

DFS SUPERINTENDENT HARRIS: Correct.

CHAIRWOMAN KRUEGER: Okay. I think that is not out there in the public eye.

DFS SUPERINTENDENT HARRIS: Okay, I will take that --

CHAIRWOMAN KRUEGER: But I'm glad to hear that.

I guess a question for both of you, because I'm a little confused who's whose responsibility. So there's a lot of complaints about the different pricing of different hospitals for the same procedures, and sometimes it's under Medicaid and there's a Medicaid amount that's going to be paid and that's that. But a lot of times it's other insurance, and some of that insurance is, say, for employees of the state and the city, it's hundreds of thousands of people, and the cost variations are enormous.

So the federal government said: You all have to tell us what your prices are.

It's my understanding not everybody's following that rule. So it's a couple of questions.

One, what can we do here in New York to make sure everybody is following that rule? Because transparency is crucial, in my opinion, even though it's a little confusing about whether consumers, as they're having the heart attack, are actually going to review which hospital will be cheaper for the care.

But, two, what are we doing to actually push the envelope of making sure that we don't have extreme price differences when you go to different hospitals for the same care?

So either or both of you.

DFS SUPERINTENDENT HARRIS: So on the issue of hospital pricing, I'll defer to my colleagues, as they oversee providers and we oversee the insurance companies.

What I will tell you with respect to insurance, and facility fees in particular, is that facility fees for preventative care

are prohibited in New York, and they must be disclosed in advance of the delivery of care for non-preventative care. That's something that we do oversee. And certainly if somebody is having a problem with that or if they were wrongfully charged the facility's fee, they should come to us and we can help rectify that situation.

CHAIRWOMAN KRUEGER: Hi. One of you from DOH, take your choice.

MEDICAID DIRECTOR BASSIRI: I can jump in. I think we've been very interested in this issue as well, not necessarily specific to the federal rule, but just general transparency and trying to leverage the all-payer database that we have in place to make sure we can understand why prices are -- why there's so much variation within the same borough, within the same block.

It is complicated, because not every procedure in and of itself is reflective of the total cost of care an individual may need. So we need to be cautious about how we use it for decision making. But we are very

interested in leveraging the APD and willing to support DFS with ensuring hospitals follow the rules.

CHAIRWOMAN KRUEGER: So -- and I'll try to ask the hospitals the same question later.

So we are working on the assumption that Medicaid reimbursement for hospital care is a reasonable and adequate amount.

MEDICAID DIRECTOR BASSIRI: We believe that it is, yes.

CHAIRWOMAN KRUEGER: You believe that. And yet the hospitals that take a far larger number of the private patients tend to be the hospitals who charge much more and seem to not fall under the safety net category of needing saving.

So is it conceivable that while we may think they are charging too much, that we are not adequately funding reimbursement for services in the safety net hospitals, which is why you had so many questions about why we have so many of them so desperate every year to be saved?

MEDICAID DIRECTOR BASSIRI: And I think there's certainly an argument to be made there.

I would just say, unlike commercial, we have a lot of federal requirements as to how much we can pay hospitals. We have upper payment limits, we have DSH cap limits, and we have to live within those structures in order to leverage the federal match.

We are making investments in rates. We're doing it across the board this year. But we are also making targeted investments in rates through the directed payments for hospitals. They are not at commercial rates -- they can't be -- but they are as high as we can possibly get the federal government to agree to.

So we are trying to make investments in our rates. We do believe we're doing that incrementally. I would just say that there are limits to how much we can do that, based on the federal rules.

CHAIRWOMAN KRUEGER: And my colleague Senator Gustavo Rivera asked you about a

whole series of reports and, I must say, had a good time playing gotcha that we finally got, apparently, a whole lot of these reports last night.

Are any of these reports -- because I have not seen them yet -- related to -- or do you owe us other reports that actually evaluate objectively what should be the different costs for different procedures in hospitals, whether it's commercial insurance or whether it's public insurance paying?

Does somebody actually have a document somewhere in prep or available, like actually, you know, the price scale is from here to here in New York, but the actual reasonable price ought to be X? Do we do that?

MEDICAID DIRECTOR BASSIRI: I don't believe we have a report like that in process.

It is a complicated question. We would want to work across the department to do that. Medicaid only has the public health insurance information. You know, the

all-payer database has some of the commercial and self-insured populations, Medicare as well. But we don't necessarily have a report like that in the works.

We could certainly try to explore that with you, Senator, if it's something that you are interested in.

CHAIRWOMAN KRUEGER: And then, very quickly, last night at the very end of the hearing we had yesterday, which was on higher education, there was a discussion about whether or not New York ought to be joining the nurses compact. And I believe the Governor has proposed us doing that in her budget.

But historically, we've never wanted to do that because of concerns about lower standards in other states. Why should we change our mind at this point when this has been working for us, so to speak --

ACTING COMMISSIONER McDONALD: It's not working for us.

CHAIRWOMAN KRUEGER: It's not working for us.

ACTING COMMISSIONER McDONALD: It's not working for us.

CHAIRWOMAN KRUEGER: Okay.

ACTING COMMISSIONER McDONALD: And it's not lower standards, it's the same standards.

CHAIRWOMAN KRUEGER: Okay, I'm sorry, I am out of time, so we'll have to follow up after that. But I would appreciate your input, and perhaps in writing others would as well, why it's not working for us and it makes sense to do this. Thank you.

Assembly.

ASSEMBLYWOMAN PAULIN: Assemblymember Jo Anne Simon.

ASSEMBLYWOMAN SIMON: Thank you, Madam Chair.

Dr. McDonald, you had said earlier you agreed that home care was healthcare. And I think many of us are struggling with the scant evidence in the Executive Budget that would reflect that.

So, somebody from the Department of Health, I want to follow up on Assemblymember

Kelles, who was referring to the financials for the managed long-term-care plans. And there are 25 plans that reported $722 million of profit in a single year in 2021. So year after year, they've been pocketing money that's meant for home care workers.

So the question is, does the state believe the plans should pocket three-quarters of a billion dollars intended for home care, yes or no?

MEDICAID DIRECTOR BASSIRI: Want me to take that one?

ACTING COMMISSIONER McDONALD: Yeah, I mean -- go ahead.

ASSEMBLYWOMAN SIMON: Yes or no, yeah.

MEDICAID DIRECTOR BASSIRI: So thank you for the question, Assemblymember.

No, we are not okay with that.

ASSEMBLYWOMAN SIMON: Okay, good.

MEDICAID DIRECTOR BASSIRI: I mean, I think if you look -- oh, sorry.

ASSEMBLYWOMAN SIMON: No, that's okay. That's great, thank you.

I just want to point out,

three-quarters of a billion would fund Fair Pay for Home Care. But that's not a question, it's just a point.

And the other issue is this claim that the home care workers should not be making minimum wage, which I agree. But we're raising the minimum wage and freezing home care wages. So the question then is how much more should home care workers be making than minimum. And if it's no longer $3, what is it?

ACTING COMMISSIONER McDONALD: I don't know that I have an exact number.

We value home care workers, and home care workers is healthcare. And it's a really growing industry. You know, since 2017, 32.9 percent are home care workers -- more than any other discipline in healthcare.

So I don't know that I know what the actual number should be, but we are committed to, you know, the increases we made. And then as the future goes out, we'll see what's possible.

ASSEMBLYWOMAN SIMON: Well, let me

just say I'd love to have a number if you could look at that and get back to us.

And just the other thing is, of course, it's healthcare but it's also, you know, under federal law we're supposed to allow people to live in their homes in a less-restrictive environment, under the Olmstead decision. And it saves New York money because it's so much cheaper to provide home care than it is to institutionalize people, whether they're in long-term-care facilities or assisted living or whatever.

So I think we all agree on what we should be doing. What we really need to do is talk about how we're going to be doing that so that we're able to achieve those goals and actually pay the workers who are doing the hard work of actually saving New York State money.

Thank you.

MEDICAID DIRECTOR BASSIRI: I agree. Thank you.

CHAIRWOMAN KRUEGER: Thank you, Assembly.

And Senator Rivera for three minutes, follow-up and closing for the Senate.

SENATOR RIVERA: I'm ba-ack.

All right, quickly. First of all, our Medicaid rates, thank you for the 5 percent. Need more, particularly because we're looking at -- we have to look at -- and this is something that I'm hoping that we do in the years to come. We need to actually invest in institutions so that they have stability so we don't have to go and save them every now and then.

So -- and we can do that by taxing the wealthy. Looking at you, Madam Governor. Do the right thing.

All right. Moving on, nursing home safe staffing money. There's $187 million that was appropriated, and it's supposed to be distributed. Has it been?

MEDICAID DIRECTOR BASSIRI: So that funding has not been distributed, Senator.

SENATOR RIVERA: Okay. Why not?

MEDICAID DIRECTOR BASSIRI: We've attempted to get approval from the federal

government on that distribution, it's a new methodology. The federal government did not approve it on the first instance. We're trying to get that approved before the end of the state fiscal year. And there's a commitment from the state to fund the state share, if nothing else.

SENATOR RIVERA: We might have some comments about some of the -- there's fundamental issues in its staffing, so that might be part of the issue. We'll get to that later.

Third, Commissioner, you've talked often about some of the work that you've done back home in Rhode Island. And I understand that you were pivotal in the implementation of OPCs over in Rhode Island. Is that correct?

ACTING COMMISSIONER McDONALD: That's right.

SENATOR RIVERA: All right. Now, do you believe -- from your experience in Rhode Island, do you believe that it's legal to fund overdose prevention centers through

opioid settlement dollars?

ACTING COMMISSIONER McDONALD: It's complicated and it's legal. And what the lawyers tell me, it's a complicated legal issue. And Senator, I hate putting the words "complicated" and "legal" together, because it means we've got to figure this out.

SENATOR RIVERA: Okay.

ACTING COMMISSIONER McDONALD: So I know -- it's something we have to figure out.

Right now I'm told it's not legal in New York.

SENATOR RIVERA: Gotcha. So we've -- we've talked about this in other hearings. I have a little bit more time now, so I just wanted to reiterate to the administration, anybody who's listening, if you could actually tell us what exactly you're referring to, that would be great. Because you keep saying that it's complicated and it's a legal issue and et cetera, et cetera. But you can't name a single thing that actually refers to limiting the legal ability of the state to be able to do that.

So could you please, couldja? And I have a couple more seconds, and I'm going to just say couldja again. And lastly, to ask very quickly about -- just state very quickly about home care, we really have to have a whole conversation about home care as well. And there has to be -- if we don't invest in it, we're just going to make sure -- we're just going to make sure that people end up in nursing homes, which is not only going to cost us more money, but it's going to be worse for those folks.

So on all of those issues, thank you for your participation today.

I am done, Madam Chair.

CHAIRWOMAN KRUEGER: Thank you, Senator.

Assembly, you have more?

ASSEMBLYWOMAN PAULIN: Yes, we have a few more. Khaleel Anderson next.

ASSEMBLYMAN ANDERSON: Thank you, Madam Chair.

And thank you to all of the commissioners who are here this afternoon.

Thank you for giving us your testimony.

I have a few questions. I'm going to start with the commissioner of the Department of Health. So the first question I have for you, Commissioner, is around the CCBHCs. So when I'm looking at the budget, the Executive proposed additional funding to the CCBHCs, and I'm just wondering what the state's objectives are to the equitable investment for those CCBHCs.

ACTING COMMISSIONER McDONALD: I'm going to let Director Bassiri handle that.

MEDICAID DIRECTOR BASSIRI: Sure. Thank you, Commissioner. And thank you for the --

ASSEMBLYMAN ANDERSON: Oh, that's Medicaid, okay.

MEDICAID DIRECTOR BASSIRI: Yeah, sure. Thank you for the question.

We've been working very closely with the Office of Mental Health on this proposal. It's part of the Governor's $1 billion proposal for mental health services. They're currently -- it's currently a federal

demonstration.

We have 13 CCBHCs. I like to think of them as comprehensive clinics that provide certain services and workforce-related investments for behavioral health and mental health needs. There's 13; we're proposing to expand it to 39 over a two-year period. And we believe it's a very great model, it's been nationally recognized, and working with OMH to implement it.

ASSEMBLYMAN ANDERSON: Thank you.

The next question is for the superintendent of DFS. Good to see you, Superintendent Harris.

So last year in the budget, of course -- and I've been very vocal on this -- was the inclusion of $11.2 million for a period of five years, every year, to help the dollar van, commuter van industry, which is critical to our, you know, economy downstate and the individuals who need transportation.

So I'm just wondering, there wasn't a request for additional funding this year, obviously because it's a five-year plan. I'm

just wondering where the expenditures of those resources are.

DFS SUPERINTENDENT HARRIS: So currently, as you know, service is an incredibly important transportation issue that's required the cooperation of many government agencies. ESD has issued an RFP -- if that's not enough acronyms for you -- to get providers for the program. DFS cannot administer that RFP because of course we are the regulator, and it would be inappropriate for us to be distributing funds.

So the funds from last year, we are very grateful to have that to begin addressing this long-standing problem. They were not used last year because the RFP has just gone out and is still currently open under ESD.

ASSEMBLYMAN ANDERSON: Thank you, Superintendent. And I'll use my last 30 seconds to ask the commissioner of the Department of Health around the safety-net hospitals investments that we made in the

budget last year. I think close to a billion dollars we did. Is that happening through the safety transformation grants, or is there another process to get those dollars out the door? The safety-net hospitals.

ACTING COMMISSIONER McDONALD: Yeah, so the $700 million investment last year was a one-time investment. There are -- there is money for safety-net hospitals, though, when you look at Statewide III.

ASSEMBLYMAN ANDERSON: No, no, no. But Commissioner, those dollars, where are they? Have they been rolled out?

MEDICAID DIRECTOR BASSIRI: They have been -- they have been rolled out through various programs, including VAPAP, VAP, and other supplemental payment programs.

ASSEMBLYWOMAN PAULIN: Thank you.

ASSEMBLYMAN ANDERSON: Thank you, Commissioner. Thank you, Superintendent.

ASSEMBLYWOMAN PAULIN: Assemblymember Gray.

ASSEMBLYMAN GRAY: Thank you very much. I appreciate it.

So first of all, Director, I just want to talk to you on the Medicaid intercept. It is a pattern of the state to be intercepting revenue from counties. They've done it with sales tax; they've done it with -- you know, for distressed aid to hospitals.

Part of the agreement with that was the tax on the -- or was a tax cap as part of the -- was the agreement on the Medicaid cap. And the counties have abided by that, by and large.

The two counties that I represent, it's going to be a 4 percent tax increase, property tax increase, and a 6 percent in the other county. So it is affecting the counties. It is a pattern of the state. They have done it in the past. And I think I would ask you to reconsider that. So ...

MEDICAID DIRECTOR BASSIRI: Thank you for the comments, Assemblymember.

I know there's been a lot of concern up to this point from various legislators. Not to sound like a broken record, but we have capped the local share of Medicaid since

2015, 7.6 billion, saving the counties, you know, over 30 billion since then. They are getting the COVID enhanced federal funding, their share of it. I think it's something we'll continue working with the counties on, and definitely we'll reconsider --

ASSEMBLYMAN GRAY: But part of that was the agreement that they would tax their property -- tax cap on their properties. So they've held their side of the bargain. The state should do the same.

MEDICAID DIRECTOR BASSIRI: I understand.

ASSEMBLYMAN GRAY: The other thing is travel nurses. They're stressing hospitals. Is there any consideration to put geo-boundaries on travel nurses?

ACTING COMMISSIONER McDONALD: The consideration we have in front of you is simply to get transparency from travel companies. You know, because quite frankly we know almost nothing about the finances regarding travel nurse companies.

I haven't seen a proposal about

geo-boundaries. Like, in other words, one of the things you're asking is, you know, can we limit how far they have to go before they're a travel nurse.

We saw this in Rhode Island, by the way, where people literally traveled five miles from their home to be a travel nurse.

ASSEMBLYMAN GRAY: That's correct.

ACTING COMMISSIONER McDONALD: The hospitals, you know, they need to be able to control their costs. And the hospitals were really at a tough time during the pandemic. And so it's something that, you know, I don't know that we can do that. What we're doing is what we can do right now.

ASSEMBLYMAN GRAY: Okay. I would encourage you to look at geo-boundaries in terms of whether they can operate within their county or a contiguous county or such.

Then the federal omnibus bill, there's $7 billion allocated for building out capacity to deal with healthcare emergencies, including stockpiling emergency supplies, including diagnostics. Does the state

have -- is the state participating in that program? It's a 20:1 match, I guess.

ACTING COMMISSIONER McDONALD: I'll have to get back to you. I'll have to get back to you on that.

ASSEMBLYMAN GRAY: Okay. Good. Thank you very much.

ASSEMBLYWOMAN PAULIN: Assemblymember Meeks.

ASSEMBLYMAN MEEKS: Thank you, Chair.

This question I guess would pertain to Superintendent Harris. Last session I sponsored a bill authorizing life insurers to establish wellness programs, and we were able to pass it in both houses, and it was vetoed by the Governor. And it was my understanding that that was referred by DFS. And just wanted to get a little more insight on that.

DFS SUPERINTENDENT HARRIS: So at DFS we offer technical assistance to the Legislature and to the Governor. We don't make the policy decisions about vetoes. Those are for the executive chamber to make. But we're always happy to provide technical

assistance on any proposal that you or your colleagues would like to put forward.

ASSEMBLYMAN MEEKS: Okay. And do you support wellness programs like for insurers and for the insured?

DFS SUPERINTENDENT HARRIS: I will tell you, one of the things that I have done since coming into the department is part of a large review that I've done -- across the department, not just in insurance -- but to look at ways that we can modernize our regs so that they are well suited or better suited for a 21st-century economy.

So we're always open to ideas where we can modernize our regulations to suit a 21st-century economy.

ASSEMBLYMAN MEEKS: Okay. And also a question -- I guess the question was posed as it relates to home healthcare workers and what would be a good wage, and it seemed to be something that's sort of up in the air.

One of the things I would consider - or suggest that you take into consideration is a living wage. I'm from Monroe County.

And before the onset of the pandemic, a living wage for a single parent raising two children was 18.50 an hour. So I'm quite sure that has increased by now.

But I think we need to get beyond the minimum wage conversation and look towards a living wage so that individuals can provide for themselves as well as their families.

Thank you.

ASSEMBLYWOMAN PAULIN: Thank you.

Assemblyman Ra.

ASSEMBLYMAN RA: Thank you.

So regarding the proposal for pharmacy service administration organizations, many have expressed the concern that this proposal somewhat misrepresents their role. So I'll start with this.

Why are PSAOs required to report information and actions that are outside of their scope of services?

DFS SUPERINTENDENT HARRIS: Thank you so much.

In fact they are not. There's been some misinformation circulating that PSAOs

are responsible for reporting drug price increases, and in fact that is not the case. The manufacturers are required -- when they distribute in New York State or they have wholesalers and distributors that distribute in New York State, the manufacturers, under this proposal, are required to report price increases to DFS.

PSAOs, along with rebate aggregators and switch companies, are required to register with DFS, and we will engage in regulatory rule-making and oversight of those organizations. Because as you noted, there's quite a lot of confusion about who in the drug supply chain is responsible for what activities. And a lot of these entities sprung up as they were spun out of PBMs or other entities in an attempt to skirt regulation. So they have continued to complicate the prescription drug supply chain.

This proposal gives DFS the authority to oversee the various entities in the prescription drug supply chain and ensure

that they're not all rent-seeking individually and therefore increasing the price of prescription drugs unnecessarily.

ASSEMBLYMAN RA: Well, I hope as this moves forward, you know, we make sure we look at that and make sure. Because there have been concerns that the registration will require information on activities that the PSAOs don't actually do.

They are also, am I correct, going to be required to pay a registration fee as -- of $5,000?

DFS SUPERINTENDENT HARRIS: I can confirm -- I can come back to you and confirm on the fee. But I don't believe that's correct. But we can confirm for you.

ASSEMBLYMAN RA: Okay. Because I know that they have usually flat fees that are, you know, pretty low that they operate on. So it seems like it would be a very high fee for those types of entities.

And, you know, my concern being, you know, you talk about the PBMs -- and certainly we don't, you know -- it was a

multiyear effort regarding the PBMs and registration, so we don't want people skirting that. But I think they have a different role, especially relative to our independent pharmacies, who rely on these PSAOs for a lot of things.

And if, you know, we were to have a too broad, sweeping new law and regulations come into effect and it had the impact of driving any PSAOs out of the market, it could have a very detrimental effect on those independent pharmacies.

DFS SUPERINTENDENT HARRIS: Absolutely.

What I will say to you is often the PSAOs fashion themselves to help the independent pharmacies negotiate, but all too often those PSAOs are owned by the PBMs, and so they are rife with conflict of interest -- which is not disclosed to the pharmacies. So these independent pharmacies are signing up with PSAOs thinking that they have a negotiator on their side, when in fact the opposite is true.

And that's why it's important for them to be subject to oversight.

ASSEMBLYMAN RA: I think oversight, certainly. But we want to make sure that it's appropriate to the role they're playing.

DFS SUPERINTENDENT HARRIS: I agree.

ASSEMBLYMAN RA: I just have one other question, if -- I don't know whether DFS or DOH could answer this, regarding the pay-and-pursuit proposal.

There's an estimated cost to the Medicaid program of $64 million in fiscal year '25. What -- do we know what the estimated cost would be regarding NYSHIP of this, at the state level and then at the local levels for municipalities and school districts, those types of entities that offer those plans?

MEDICAID DIRECTOR BASSIRI: I believe they're exempt from the legislation, so there shouldn't be any fiscal impact. Self-insured is not part of the pay-and-resolve bill.

ASSEMBLYMAN RA: Okay. And are you aware -- you know, I have heard that a number

of large unions have expressed opposition to this proposal. Would this proposal affect fully insured unions?

MEDICAID DIRECTOR BASSIRI: Yes, I've heard their concerns as well. They are exempt. I think it's just, you know, a longstanding policy issue that they are concerned about. But they're exempt from the legislation.

ASSEMBLYMAN RA: Thank you very much.

ASSEMBLYWOMAN PAULIN: Thank you.

Second round, Assemblymember Weprin.

ASSEMBLYMAN WEPRIN: Thank you, Madam Chair.

Thank you, Superintendent, for being here again and spending so much time with us.

I know the Governor and myself as well are committed to mental health services and trying to -- you know, and I know in her budget and her State of the State she emphasized the importance of parity with mental health services.

There's a problem, though, with private providers of mental health, the whole

spectrum of providers, with reimbursement rates. Private rates are generally lower than the Medicaid reimbursement rate for mental health services.

Would your department consider mandating a minimum reimbursement rate for mental health services?

DFS SUPERINTENDENT HARRIS: So currently we don't set reimbursement rates. But certainly if you have a proposal that you would like us to provide technical assistance on, we're happy to do so.

What I will say with respect to mental health and substance use disorder parity is we've got robust requirements on the books. Insurers are required to provide DFS with reports every two years, and those reports are made public on our website. And where insurers don't comply with their parity requirements, we bring enforcement actions. And I've brought a couple in my short time at DFS.

ASSEMBLYMAN WEPRIN: Okay. I may get back to you on that.

DFS SUPERINTENDENT HARRIS: Please.

ASSEMBLYMAN WEPRIN: Thank you.

Thank you, Madam Chair.

ASSEMBLYWOMAN PAULIN: (Mic off.) Thank you.

So I'm left, just for my cleanup. So I'm going to talk fast; I'm learning from my colleague here to the right.

(Laughter.)

ASSEMBLYWOMAN PAULIN: Medicaid recertification is bound to be a nightmare in certain areas. I wonder if the department has thought about continuous enrollment for children under six so that needy children don't lose their coverage. Or might consider it.

MEDICAID DIRECTOR BASSIRI: We would definitely consider that, Assemblymember Paulin. I think we would need an 1115 waiver to do that. We currently have an 1115 waiver pending at CMS, so we would have to wait until we get that approved. But it's something we've been looking at and interested in as well.

ASSEMBLYWOMAN PAULIN: Thank you.

Quality pools, eliminated in this budget. It doesn't seem to be in line with the mission of the department to look for better plans. Wondered about that.

MEDICAID DIRECTOR BASSIRI: I can understand why you think that.

ASSEMBLYWOMAN PAULIN: Oh, my light's not on. No, it's not. Oh, and there we go. Well, you heard me anyway.

MEDICAID DIRECTOR BASSIRI: Yeah. Yeah, I heard you, quality pools.

ASSEMBLYWOMAN PAULIN: I'm taking an extra second.

MEDICAID DIRECTOR BASSIRI: Yeah, I can understand why you think that. I think, you know, we expect more from our health plans from an accountability standpoint. I think you see that throughout the Medicaid budget.

There will be other opportunities, there are other opportunities for quality incentive programs through the Essential Plan. And we are, as I mentioned, seeking an

1115 waiver, 13.52 billion, that will be significant quality incentive opportunities for the health plans when we get that approved.

ASSEMBLYWOMAN PAULIN: CDPAP. The wage parity protections are being eliminated in the Article VII. Rationale?

MEDICAID DIRECTOR BASSIRI: I think we're going to need more than a minute and a half to talk about that. So maybe we can get back to you.

ASSEMBLYWOMAN PAULIN: Okay.

And the last question, EMS. Big improvement over last year in terms of bringing in the players and the industry, so to speak. Two things I wondered about, because they're not in the SEMSCO report, and that is to do with the CON, transferring that to the state. And also setting up the regional -- the 10 regional districts, which is also not in the report. I wondered, you know, why that.

ACTING COMMISSIONER McDONALD: The 10 regional districts, why that's in the --

ASSEMBLYWOMAN PAULIN: Why -- those are two things that were not in the 79-page report which I read.

ACTING COMMISSIONER McDONALD: Right. I read it too.

ASSEMBLYWOMAN PAULIN: And wondered, you know, why they were included and never having been talked to or vetted with the stakeholders.

ACTING COMMISSIONER McDONALD: The state's already in 10 regional directs. From what I understand, it was just ease of implementing. So that's why.

ASSEMBLYWOMAN PAULIN: And just to comment, with my last 19 seconds, I would echo Jen Lunsford's suggestion about looking at EI. I did that covered-lives bill. The intent was to cover and to provide more services for children. And if you look today, there happens to be a Comptroller report indicating that children are not getting served.

ACTING COMMISSIONER McDONALD: Thank you.

CHAIRWOMAN KRUEGER: Is that it?

ASSEMBLYWOMAN PAULIN: That's it.

CHAIRWOMAN KRUEGER: Okay. And the Senate is done, the Assembly is done, which means you are finally done. So it was a little longer than we expected, but you got a break in the middle.

(Laughter.)

CHAIRWOMAN KRUEGER: So thank you very much for your testimony. We look forward to seeing the responses in writing on questions that you knew you didn't have the answers to now or weren't allowed the time to answer for us.

So as everybody takes a little bit of a stretch break -- but not very long, don't go anywhere -- we will be calling up the Greater New York Hospital Association, Kenneth Raske; the Save New York's Safety Net Coalition, Jacquelyn Kilmer; and the Healthcare Association of New York State, Bea Grause.

And also, everyone, if you would please take the conversations you might feel

a need to have with our guests out in the hallways, that would be appreciated.

(Brief recess taken.)

CHAIRWOMAN KRUEGER: Now we're starting up again, thank you.

And we're going to our Panel A, our first nongovernment panel. Remember, everybody, the rules have now changed. They each get three minutes, which I know they think is crazy, and we only get three minutes. So we are going to be very good at being concise and specific.

And when you are asked questions that you won't possibly have the time to answer, you will say "Look at my testimony which I couldn't read to you," or "I will get back to you." And if you get back to Helene Weinstein or myself, we will make sure that it gets to all the members of the committees as soon as we get it from you all.

So why don't we start in the order that you're on the panel, with Ken Raske from the Greater New York Hospital Association.

MR. RASKE: Good afternoon,

Madam Chairman, and good afternoon to the members of the Senate and Assembly.

I have an opportunity in this three minutes to walk you through the panels which I provided in our testimony. And I'm going to isolate only a handful to get this presentation started and completed.

The first one is profitability. I have a panel of four in the handout, which deals with the miserable financial performance of hospitals in New York State. And it's a story of one loss after another. And as you can see from the panel, four out of five hospitals are not on a sustainable path. This is undoubtedly one of the worst performances in the United States. That, ladies and gentlemen, is the baseline for this presentation.

So going in, the hospitals in many of your districts are losing everything but their shirt. So let's go to the second panel, which is some of the causes of this. right now we have an explosion due to the labor shortages and labor costs. And what

I've done in this panel -- this is Panel 5 -- is taken, say, the most recent labor settlements and taken them out in a ripple effect across a broad sector of institutions by percentage of penetration.

And as you can see from this table, this goes into the multi-billions of dollars in very quick fashion. And that's the labor costs that we're seeing escalating as of the moment that we speak.

So based on the financial performance and the labor cost implosion, this creates the vise that I'm talking about.

Now go to Panel 6. Panel 6 gives you an idea -- and some questions came earlier about what does Medicaid pay in New York. Medicaid is, in a payment basis in New York State, is the worst in the United States. Okay? The worst in the United States. Now, that is a statement that you probably haven't heard before, because we have an extensive coverage and benefits program. But the payment for it is miserable. And right now hospitals are receiving 61 cent on a dollars

of cost -- 61 cents on a dollar of cost.

Now I'm going to go to another segue, which is the insurance companies and the abuses, and that was a subject that some have raised before. There are two proposals within the Governor's budget that we like, one on pay and review, and another one on site of service. Site of service is a way for payers to not pay hospitals but rather direct them into ambulatory surgery centers, which have none of the overhead costs like emergency rooms at hospitals have. So these are two proposals that warrant consideration.

Now, let me just conclude very quickly by taking you to insurer profits. Ladies and gentlemen, I have mapped out two large insurers in New York State, United and Elevance, which is Anthem -- Blue Cross in terms of your vernacular. They show the profitability, which is astronomical, in the last few years. This is --

CHAIRWOMAN KRUEGER: Thanks, Ken, your time is up.

MR. RASKE: All righty.

CHAIRWOMAN KRUEGER: Sorry. Thank you.

Okay. Hi, Bea -- oh, no, sorry, excuse me. Jacquelyn.

MS. KILMER: Is this on? Okay.

So good afternoon, and thank you very much. My name is Jacquelyn Kilmer. I'm the CEO of Harlem United, but I am here today testifying on behalf of the Save New York's Safety Net Coalition. The coalition is a statewide coalition of community health centers, Ryan White services providers, and Medicaid HIV Special Needs Plans. And I'm testifying regarding the pharmacy carveout.

The coalition strongly opposes the carveout proposal in the Executive Budget, and we urge the Legislature to adopt the alternative that is currently set out in S5136, introduced by Senator Rivera last week.

We are just one short month away from the effective date of the carveout, when the safety net providers at that point will face a fiscal cliff that will devastate us, and it

will devastate the communities that we serve.

And at this point I do want to follow up on something that Senator Rivera pointed out earlier and clarify something that was said in earlier testimony, which is it is the 2.3 million community members that we serve that will be impacted by this carveout. Two hundred fifty thousand may be the number of Medicaid members who receive a 340B prescription. That also does not include the uninsured New Yorkers who receive free medicines from that program. And it absolutely does not include the 2.3 million community members that the safety net providers serve, who will be impacted negatively by this carveout.

The solution in the Executive Budget is flatly unworkable. The solution isn't simply to throw more money into a pool in an attempt to make us whole. That's what the current proposal does. But it isn't a solution because it isn't reliable, it isn't certain, and it isn't bankable, as the 340B reimbursement mechanism is.

The proposal is subject to budget negotiations. It is not a permanent solution. It is subject, as we know, to CMS approval, and that plan hasn't been submitted to CMS yet. And again, we are only 30 days away from the effective date of the carveout.

And even if CMS approves the plan, there is nothing that obligates the state to actually make those payments. So there is still extreme uncertainty for all of us in the safety net who rely on this reimbursement mechanism.

But there is a workable solution, and that solution is contained in S5136 that Senator Rivera introduced last week. It is -- it provides the best of both worlds. It maintains the carveout. It maintains the benefit -- excuse me, it maintains the pharmacy benefit in managed care, and therefore the 340B reimbursement mechanism remains intact. And it addresses the state's policy objectives.

It also solves, for the community pharmacists -- thank you.

CHAIRWOMAN KRUEGER: Thank you.

Hi.

MS. GRAUSE: Good afternoon, Chairs Krueger, Weinstein, Rivera and Paulin and all the other members of the Assembly and Senate. My name is Bea Grause. I'm the president of the Healthcare Association of New York State.

I wanted to start out by emphasizing what Ken said, in that our hospitals are in a structural fiscal crisis. There are two reasons for it. One of them is the workforce shortage, and the other is chronic underpayments, where Medicaid reimburses 61 cents on the dollar of cost. This crisis has already caused hospitals to cut services, halt modernization projects, and many -- four out of five of our hospitals are reporting negative or unsustainable margins.

In addition, it has impacted nursing-home beds, which are closed across the state, and nursing homes are struggling to keep their doors open, as much of this testimony earlier today has emphasized. And what has happened is that it has caused

system gridlock, which really is furthering the fiscal deterioration for hospitals and nursing homes.

We have three requests for you. The first is we are asking you to dramatically improve Medicaid payment rates while restoring state supportive funding for financially distressed hospitals and nursing homes. Among our many priorities we urge you to consider a minimum 10 percent increase to the Medicaid rate for hospitals, including both inpatient and outpatient rates, as well as a 10 percent Medicaid rate increase for nursing homes. We need to stabilize our hospitals, but again, I think this funding needs to be continued.

Second, we urge you to advance key healthcare policies that provide much-needed relief to hospitals and health systems while imposing little to no cost to the state. There are many opportunities to do so, like making permanent workforce flexibilities and taking steps to address the abusive practices of well-resourced insurers that burden our

hospitals and other providers, pay and resolve being one of them.

Third, we urge you not to make any cuts to hospitals and nursing homes and refrain from layering on new unfunded costs. The Executive Budget couples the proposed Medicaid rate increase for hospitals with the advancing of the Medicaid pharmacy carveout. The result for many hospitals participating in the 340B drug pricing program is a net negative -- at a time when they simply cannot absorb any further cuts.

Meanwhile, the nursing home Medicaid rate increases, coupled with the elimination of 187 million in previously appropriated but never released funding meant to support increased staffing -- our nursing homes needed that money when it was appropriated, and they certainly need it now.

There are many other priorities in my written testimony, and I will reserve the remainder of my time. And back to you, Chairman Krueger.

CHAIRWOMAN KRUEGER: I'm so sorry.

Thank you -- excuse me; Lynne showed up at the wrong time.

(Laughter.)

CHAIRWOMAN KRUEGER: Excuse me.

Our first questioner will be Senator Rivera.

SENATOR RIVERA: I'm good right now.

CHAIRWOMAN KRUEGER: You're good right now. Then I will pass it to -- also good?

Senator Helming.

SENATOR HELMING: Thank you.

Thank you for your testimony. A quick question for you. During the last panel discussion, the Medicaid director -- I think I heard him state that he has seen an increase in the denials by health insurers for our safety net facilities. Is that something that you can corroborate?

MR. RASKE: You want me to -- {inaudible} if I can. The answer is we've been tracking that. We're talking about a denial rate, generally speaking in New York State, of about 25 percent. Then they go to adjudication, through an appeals process, and

then most of those are ruled in favor of the hospitals, at least in large part.

With respect to the observation on the safety nets, we are hearing that too. And it is now a not confirmed statement, but rather anecdotal. We're in the process of trying to confirm it, though, and we're collecting that evidence as we speak.

SENATOR HELMING: I'd be interested in seeing that data.

Just trying to get to the bottom of this pay and resolve, I understand that both Greater New York Hospital Association and HANYS are in support of the proposal that is in the budget. My concern is that it seems to be, when I read it, that it is -- it would add further delays, further time until you receive your decisions.

MS. GRAUSE: It would not. It would not. It would require the payers to pay for emergency services and inpatient services subsequent to an emergency admission. So it would not -- it would not delay payment. They would be required to pay within 30 days.

SENATOR HELMING: Thank you for that.

And just on the 340B carveout, again, I think you heard me during the last panel. I hear you. I have assurances from my colleagues here that that is definitely a priority to fix that.

Thank you again for your testimony.

MS. GRAUSE: We appreciate that.

MR. RASKE: Thank you.

CHAIRWOMAN KRUEGER: Thank you, Senator Helming.

Assembly.

ASSEMBLYWOMAN PAULIN: Assemblyman Weprin.

ASSEMBLYMAN WEPRIN: Thank you, Madam Chair.

Thank you for your enlightening testimony. I've been a strong advocate for actually a 20 percent Medicaid reimbursement increase in this budget, and I've said that publicly, I've written a letter to the Governor to that effect, along with many of my colleagues in the Assembly and Senate.

Mr. Raske referred to that we were one

of the lowest if not the lowest state in reimbursement at 61 cents. Where do we fit in the realm of the 50 states? What number are we in that list?

MR. RASKE: What number are we in the 50 states in terms of the --

ASSEMBLYMAN WEPRIN: The lowest reimbursement --

MR. RASKE: Yeah, you know, the interesting -- the Medicaid statement that I made was picked up in a City & State seminar on Friday, and a professor from Cornell came up with that observation that looking that all 51 jurisdictions, that New York was the lowest. And it was through her studies, and we cited that in one of our tables, sir.

ASSEMBLYMAN WEPRIN: Okay, and who's the highest?

MR. RASKE: I do not know, but I could find out for you and get back to you with that information.

ASSEMBLYMAN WEPRIN: Yeah, I think it would be helpful in this budget discussion as we're getting closer.

But I want you to know --

MR. RASKE: In fact, with the permission of the chair, I will give you the list of all the states from the professor and her study, so you can have them all.

ASSEMBLYMAN WEPRIN: Sure. You can send it to me directly. I don't think you need the chair's permission.

MR. RASKE: Well, I was going to give it to the entire panel.

(Laughter; overtalk.)

MR. RASKE: Your colleague was shaking her head yes, so I'll give it to everybody.

ASSEMBLYMAN WEPRIN: No, no, I appreciate that. And, you know, as we all -- I have a lot of hospitals and nursing homes that are really in trouble because of the reimbursement rate on Medicaid, so --

MR. RASKE: Yeah, the safety-net problem warrants a separate discussion. It is a big, big problem.

And if I could just add one comment quickly, and that is the safety-net funding in the budget is grossly inadequate. It is

minus 700 from last year. And we are fighting, us and 1199 and our colleagues in HANYS are trying to get that restored plus some additional money, as Bea spoke to. And that is essential.

In other words, think about the incongruity of what I just said. We are fighting to put money into the budget so that the executive branch could have enough money to bail out hospitals that run aground. Now, I'm trying to help the executive branch actually do their job down the road. That's what we're trying to do. And I consider that an incongruity, sir.

ASSEMBLYMAN WEPRIN: Well, we appreciate your advocacy. Thank you.

MR. RASKE: Yes, sir.

CHAIRWOMAN KRUEGER: Thank you.

Do we have any other Senator who wishes to ask questions?

Senator Rivera.

SENATOR RIVERA: While I kind of have lunch. So I wanted to give an opportunity to all of you to kind of chime in on the 340B

situation, particularly since there's a -- since obviously there's a concern, I mean, we stopped the presses, if you will, because people were so fired up about it that they actually shut this down.

So I wanted to give an opportunity to everybody to kind of chime in on this. Start from the right and then go that way (gesturing). I know that you have a big part of your testimony was that, but -- if you could, Bea.

MS. GRAUSE: Sure. So I think the importance of 340B is really access to patients. And hospitals across the state have built programs as a result of the savings that they receive to help create mobile vans, create programs that will get HIV drugs to difficult-to-treat populations. And those programs are incorporated in their capital plan and their overall budget. So they're built into their strategy.

So I think unraveling and taking away those savings really provides no available source for these hospitals to continue these

programs. So it's incredibly important for patient access.

MS. KILMER: I think another point that I'd like to make is that the state, the safety-net providers, and the millions of New Yorkers who depend on the services that we provide are actually facing a perfect storm right now. So we are in a situation where we are needing to recertify 8 million Medicaid members. There is an increasing number of immigrants coming into New York, all of whom are going to need healthcare and will be getting their healthcare from the safety-net providers. And we have the carveout. Those three things are unworkable. They are just simply an unworkable situation.

MR. RASKE: Just to add one further comment on it, in the budget there is an increase of 5 percent on Medicaid payments. This is the first we've seen in 15 years. But that is washed out by the 340B.

So it basically -- you know, they give on one hand, take on the other. And that's what this story is all about. If that's

clear, Senator.

MS. GRAUSE: I would just add to that, in that we -- in the critical condition report that Ken, I and others completed and you have in your packet -- really demonstrated that expenses are well above revenue. And while we appreciate what's in the Governor's budget, it really doesn't even get hospitals back to zero.

And that's really not what we need now. We really need that investment in Medicaid. We need those policies that will help hospitals that don't cost the state any funding. And we certainly don't need any cuts like 340B.

CHAIRWOMAN KRUEGER: Assembly?

ASSEMBLYWOMAN PAULIN: Yes. We have a list.

Assemblymember Jensen.

ASSEMBLYMAN JENSEN: Yes, if I can get my microphone working -- or not. Is it working? Okay, perfect.

Ms. Grause, following back up to your testimony, you alluded to some of the

staffing crisis and shortages that our hospitals are seeing across the state. We still have in place a vaccine mandate that's artificially limiting available care staff from being able to work.

From your perspective, what should the state be doing to help reinvigorate staffing both in hospitals and our nursing homes, especially with more and more mandates ending up on the long-term-care side of the equation?

MS. GRAUSE: Thank you, Assemblyman Jensen, for that question.

I think the short answer is everything. There -- you know, as you know, I'm a former emergency room nurse, and you really can't have a healthcare system without people taking care of people. And the workforce shortage is complex, and I think there are immediate, mid-term and long-term initiatives that are in the Governor's budget that are designed to really improve that pipeline and bring more healthcare workers back into clinical settings.

As you were saying with the vaccine mandate, that, as you know, the state has until March 20th to perfect their appeal in the Fourth Department. And so right now there's the status quo, certainly, in that. So we are certainly looking to -- we're monitoring that very closely, but I think that the Governor has made it clear that healthcare workers need to be vaccinated, and that is the state's position.

But in addition to that, there are many other things that we can do to provide flexibility. We support the participation in the compact, for example. We support many of the Governor's initiatives to make permanent many of the workforce flexibilities that were included in the executive orders during the pandemic.

ASSEMBLYMAN JENSEN: So going back to -- we've seen money in the budget the past two years for helping the nursing homes deal with some of the staffing mandates that have been in place. That money never actually made it to those providers.

If the state more appropriately invested in reimbursement rates, would that alleviate some of the backups that we're seeing in EDs across the state?

MS. GRAUSE: We believe it would.

And again, as I alluded to before, there's system gridlock. And when there aren't enough home care workers, when there aren't enough nursing home open beds, you have -- you know, when you think about all the open healthcare doors in a community, a hospital's emergency room doors are always open. So when all those doors are shut, patients come through those emergency room doors.

And patients -- the demand is there, so patients are continuing to go into the hospital and then they cannot be discharged out into the community. And that's what -- so opening those doors elsewhere would help with hospital emergency rooms.

ASSEMBLYMAN JENSEN: Thank you.

CHAIRWOMAN KRUEGER: Thank you. For the Senate.

So according to the Nurses Association, we have 355,000 licensed nurses in New York State. But according to federal BLS data, we have 188,000 of them working as nurses. Why can't we get nurses that are already living here and licensed here to go to work for you all?

And, follow-up -- this is for all three of you -- why are some of your hospitals ending up paying three times the amount per hour for traveling nurses? What are we doing wrong?

MR. RASKE: Bea, you want to start, or would you like me to?

MS. GRAUSE: Sure.

I think that's a fabulous question. I think many hospitals are doing a lot of soul searching to try to find ways to bring nurses back into the workforce. I think there certainly has been burnout from the pandemic. And I also think that the nursing population, or the workforce, is aging, and so many retired early. So they may still be actively licensed, but they have decided to retire.

So -- but I do think more research is needed into that question.

MR. RASKE: I'd say -- I'd only add, Senator, you probably are seeing a significant wage adjustment going on within the nursing community due to the shortage issue, driven in large part by burnout from the pandemic.

And that is the natural market forces as well as collective bargains. We have the NYSNA contract which just was concluded, which also involved a strike at two major institutions, and then we have a request from 1199 to reopen their contract. And that is being given serious consideration by the hospitals that have 1199. And 1199 has been a great partner on healthcare policy issues throughout the years, so I'm sure that reopener will occur.

CHAIRWOMAN KRUEGER: But we also heard from a previous question on the previous panel that we have a lot of traveling nurses who actually aren't traveling. They actually live within a few counties of where they are

now working.

So I think there's a bigger problem with all this. And I'm even hearing that we're having sort of wars between different New York City hospitals to take each others' nurses.

MR. RASKE: Sure. Absolutely.

CHAIRWOMAN KRUEGER: So it seems to me we need a more global solution than just watching you having range wars between different hospitals and ending up with paying people three times what the actual permanent nurses who work for you are making.

MR. RASKE: We certainly would agree with you.

MS. GRAUSE: I think there are a lot of issues in flux there, and I think it does warrant some additional review.

I would just comment that it is a national workforce shortage, which I think has exacerbated many of the issues you raised.

CHAIRWOMAN KRUEGER: Yeah, I'm not saying we don't have a shortage overall. But

it seems like we have nurses that we're not using as nurses, or nurses who will work on the traveling nurse model because they can get paid three times -- I guess I would take the job that paid me three times what my other nurses who had, you know, salaried jobs take. Right? I would too.

My time is up. Assembly.

ASSEMBLYWOMAN PAULIN: Yes. Who didn't we -- okay, I guess in order, Assemblymember Gandolfo.

ASSEMBLYMAN GANDOLFO: Thank you, Madam Chair.

So in last year's budget there was I think roughly 800 million allocated to assist hospitals that were struggling due to the pandemic. So my question to you is, have any of your member hospitals seen any of that money that the Legislature allocated in the budget?

MS. GRAUSE: No. Not to our knowledge. You worked very hard to put that money in the budget for hospitals last year, and I think as you heard, the Medicaid

director testified that that money was spent, and we believe on the federal match for the DPT program. So we feel very strongly that that funding should be restored for hospitals.

MR. RASKE: I would only add that if you take a look at that panel that I referred to earlier as it relates to the hospital margins, we superimposed the provider relief fund that the feds gave us.

And if they did not provide that relief, we would have a wholesale crisis in New York. Because the margins would have been dropping like a brick, and it would be awful. And my thanks to our leadership in the Congress for doing that. But it has not been augmented, Bea, from the legislators' point of view.

ASSEMBLYMAN GANDOLFO: Thank you.

You all spoke of, you know, the fiscal troubles that hospitals and healthcare facilities are facing. It would be great if the money that's allocated for a purpose -- to assist those struggling hospitals --

actually gets there. So thank you very much.

MS. GRAUSE: Couldn't agree more.

ASSEMBLYWOMAN PAULIN: No more Senate, right?

CHAIRWOMAN KRUEGER: No more Senate, just double-checking.

It's yours, Assembly.

ASSEMBLYWOMAN PAULIN: All right. Assemblymember Bronson.

ASSEMBLYMAN BRONSON: Thank you, Madam Chair.

And Ms. Kilmer, thank you for correcting the record. I don't know if you were here earlier, but 250,000 --

MS. KILMER: Yes.

ASSEMBLYMAN BRONSON: -- is woefully understated.

But more importantly, we're talking about 340B, which saves lives. So whether you say 250,000 or you say 2.3 million, we need to save those lives.

MS. KILMER: Yes, exactly.

ASSEMBLYMAN BRONSON: Thank you for that.

You mentioned, under the compromise, that we're meeting what the administration's goals are and what they're trying to do. And we're meeting them with more certainty, more reliability, and not dependent on what CMS does and things of that nature. But you also stated that we're saving community pharmacists. Can you expand on that a little bit?

MS. KILMER: I can.

So we believe that the alternative bill, alternative language does actually solve the community pharmacists' issues. The issues that they've raised are their dispensing fees, objective drug pricing, and restrictions on the anti-competitive business practices of the pharmacy benefit managers. And all three of those things are specifically addressed in S5136.

ASSEMBLYMAN BRONSON: Thank you. Appreciate that.

Mr. Raske, you've mentioned the troubles our hospitals are facing. Certainly in my district, in my area, the University of

Rochester Medical Center, Rochester Regional, have shared with me their numbers. They've also shared how the 5 percent will be eaten up by the 340B. They both participate in that program.

But more importantly, that we are now in a crisis in meting out patient quality care because of the staffing issues, because nursing homes have vacant beds but they don't have staffing and they don't have the reimbursement rate to bring in more staffing. So they can't accept patients who are ready for nursing home care. They can't move patients from emergency rooms up to other levels -- lower levels of care in the hospital.

I too support a 20 percent reimbursement rate increase. But the question is what -- are there any strategies in this budget to address those concerns? Or do we have to rely on the reimbursement rate increase, which we're going to fight for. But are there any strategies that the administration's fighting for that meets that

crisis?

MR. RASKE: Well, the budget recommendations that we are talking about include component parts. One is, of course, a rate increase and the mention of that on the hospital side and the nursing home side as well. Another component part is to wash out the 340B impact, which gives you a net zero. So if you restore that, that would help provide support on the rate side.

Then a recommendation is also, for financially struggling hospitals, to add 700 million back to them plus an additional amount, which we think could be in the neighborhood of another half a billion dollars --

ASSEMBLYWOMAN PAULIN: Thank you.

MR. RASKE: -- to that fund.

ASSEMBLYWOMAN PAULIN: Thank you.

ASSEMBLYMAN BRONSON: Thank you.

MR. RASKE: And that should take care of it, sir.

ASSEMBLYWOMAN PAULIN: Assemblymember González-Rojas.

ASSEMBLYWOMAN GONZÁLEZ-ROJAS: Thank you all so much. I really appreciate your advocacy specifically on 340B -- actually, all the issues you're fighting for. But I think the connection between the low reimbursement rate and the 340B situation dynamic is really elucidating.

I want to raise something that I raised earlier about coverage for immigrant New Yorkers. As you know, there might be an opportunity, through the -- a waiver, through the Essential Plan, in order to expand coverage, and we're finding out the dynamics a little bit more.

But right now, as I understand it, we spend $550 million on emergency Medicaid. Can you talk about what that means in terms of the infrastructure of the hospital and maintaining its health and wellness? And also, what could that money be used for if we're able to get Essential Plan coverage for our immigrant populations that are now relying on emergency Medicaid?

MS. GRAUSE: I can't speak

specifically to that proposal, but we have long supported coverage for all who need it. And so I think having coverage for immigrants would help hospitals in that the services that they provide would have some measure of reimbursement. So it would help.

MR. RASKE: I can tell you this, from the Greater New York Hospital Association point of view. We believe everybody should be treated with dignity and respect and the best possible hospital care, and that's every human being that we see. And if there's a proposal to expand coverage, we're in it. We support it.

ASSEMBLYWOMAN GONZÁLEZ-ROJAS: Because as you know, you know, those who can't get preventative care are going to the emergency room when their situations are untenable, and it will actually cost us a lot more money -- and not just in dollars, but in the health and well-being of our New Yorkers.

So thank you so much.

ASSEMBLYWOMAN PAULIN: Assemblymember Kelles.

(Off the record.)

ASSEMBLYWOMAN KELLES: So a couple of things. I'm curious of your assessment -- this is what I'm seeing in this budget -- that overall there have been cuts on the operational side of things, cuts and not needed increases in wages. And the money that's been added has been primarily capital, one-time investments. I'm looking at your list here: $1 billion capital fund, and yet 700 million safety net reduction; $83 million in Indigent Care Pool.

Is that generally your assessment or your experience that's happening with this budget?

MR. RASKE: Well, we've seen the -- there's a couple of phenomena going on -- can you hear me? Yes, okay -- one of which is because the operating support of the hospitals is so miserable, they have cut off their capital expenditures, about half of the hospitals -- right, Bea?

MS. GRAUSE: More than half, yes.

MR. RASKE: -- have curtailed their

major capital expansion plans. Now, that's going to ripple out throughout the economy.

The amount of money in the budget, a billion dollars that the Governor has put in, is great. But it's probably a multiple of that that is actually needed. Particularly if we're not getting the support from the operations end of the equation. Is that clear?

ASSEMBLYWOMAN KELLES: I do have one question -- yes, absolutely.

What will be the impact of the $83 million Indigent Care Pool cut? What would that look like?

MR. RASKE: You know, I don't even understand why they did that --

ASSEMBLYWOMAN KELLES: I don't either, but I'm asking what will that look like.

MR. RASKE: I don't -- Bea, maybe you can explain it to me.

MS. GRAUSE: I mean, I think what you're speaking to I think is generally correct, in that when we talk about a structural fiscal crisis, it's both chronic

and acute. And the chronic part is because of the years and years of no investment in Medicaid rates --

ASSEMBLYWOMAN KELLES: In the operating.

MS. GRAUSE: -- in the operating side. And then you have the 340B policy and the cut to indigent care, and all of -- it more than undercuts the 5 percent inpatient rate increase. So it really doesn't change anything around -- it doesn't create an investment in the infrastructure. It's a zero-sum -- it's less than a zero-sum game on the operating side.

ASSEMBLYWOMAN KELLES: That's what I'm looking at too.

MS. GRAUSE: And then the billion dollars in capital, et cetera, is all one-time dollars. And again, I think to Ken's point, is hospitals aren't in a financial position anymore to take advantage of the capital.

(Overtalk.)

ASSEMBLYWOMAN KELLES: I'm going to

grab my last 33 seconds.

Yes. Just really quickly, I'm seeing these increases in profits of the healthcare plans. Do you think that they are passing through to you all the amount of legally required direct payments to you that they're required of --

MR. RASKE: I think absolutely not.

MS. GRAUSE: No.

MR. RASKE: And here's the problem. You know, when you hear some of the -- when we put the proposal of pay and review out there, as an example, or site of service -- people will say, well, gee, this will somehow involve -- I don't know why this thing keeps on going off on me here, but --

(Laughter.)

MR. RASKE: Is it me or is it something I ate?

(Laughter.)

ASSEMBLYWOMAN PAULIN: Thank you.

MR. RASKE: How can you explain this without this -- with this clock keeping on beeping?

But what -- what the -- some of the opponents to this proposal are saying, Well, it's going to increase premiums. I say baloney. If you take a look at the profitability of these companies and what their market caps are and what's going on on Wall Street, they're outperforming the Dow Jones. Why? They've got my money, that's why. And that's the problem.

ASSEMBLYWOMAN PAULIN: Thank you.

ASSEMBLYWOMAN KELLES: Thank you.

MR. RASKE: Thank you.

ASSEMBLYWOMAN PAULIN: Assemblymember Palmesano.

ASSEMBLYMAN PALMESANO: Good afternoon. My question -- well, it's not so much as -- I want to address it to Bea, if I may, just because a lot of HANYS is in my district.

MS. GRAUSE: Sure.

ASSEMBLYMAN PALMESANO: Particularly I know in the earlier panel there was much discussion and questions surrounding the issue of pay and resolve. And can you

briefly talk about the impact this proposal would have on your member hospitals?

MS. GRAUSE: Sure. It's really about cash flow. And we think that, you know, having emergency services and inpatient admissions that are subsequent to an emergency stay, having the payer having to pay that within 30 days -- now we have prompt pay laws on the books, but there's a lot of ways that the payers -- and they do -- delay payment.

So it's really about cash flow. And I think the payers will come in and they'll tell you that it's going to raise premiums, as Ken was saying. We don't think that's true, because again, I can tell you from personal experience, when patients are in the emergency room, there's an emergency. And that realtime care should have realtime payment attached to it.

So we think it's really for hospitals. The benefit is cash flow. We do not think there will be an overall increase in premiums as a result, because those claims should be

paid.

ASSEMBLYMAN PALMESANO: Actually, I'm also hearing from a lot of hospitals in my district, some that are associated -- they have ownership in long-term-care facilities. And I know that the new nurse staffing ratios that were put in place require, I believe, three and a half hours of direct patient care per day.

And in order to be compliant with that, I've heard that there's hardships because they can't find enough certified nursing aides. And that's really -- some have had to close down beds on units because of that. And it really has had a negative impact on reimbursement opportunities, and also jeopardizes the 40/70 rule.

Can you elaborate on that? I mean, what can we do to -- and we also have to increase reimbursement because -- and how that's problematic?

MS. GRAUSE: I think -- as Ken and I have both spoken, I think it really does boil down to, at this point, wage increases.

Because in -- across the state more than 2,000 nursing home beds have closed since before the pandemic. And that -- that closure in large part has happened because of the requirements of the ratios and the inability for nursing homes to find qualified workers.

So raising wages would help with that. Hopefully it would help to open those beds. And it would reduce that system gridlock that I was talking about before.

MR. RASKE: Ditto.

ASSEMBLYMAN PALMESANO: Ken, 20 seconds if you want to add on there. Anything else that you have to say? You're good? Okay.

MR. RASKE: That was it.

ASSEMBLYMAN PALMESANO: Perfect, thank you.

MS. GRAUSE: He said ditto.

MR. RASKE: I said ditto, yeah. I would agree with it 100 percent.

ASSEMBLYMAN PALMESANO: Then I gladly yield back my 10 seconds to the chair.

ASSEMBLYWOMAN PAULIN: Okay. I think I'm here to close. Two things.

First, on hospital closures, your testimony is in direct contrast with the department in terms of having enough resources to make sure that hospitals don't close. Is it -- do you believe that we're going to see hospital closures if the budget goes forward as it is?

MR. RASKE: You know, this is a really important question, Madam Chairman. And the answer is -- I think I made mention of it -- we're trying to give the department more tools to have by adding back money that they deducted from last year. If they spent everything last year to bail out hospitals, how can they have $700 million less this year? It doesn't add up, does it?

ASSEMBLYWOMAN PAULIN: Well, maybe --

MR. RASKE: And I'm going to give them more money --

ASSEMBLYWOMAN PAULIN: No, I understand. I understand. But do you actually think there's going to be closures?

And/or what services are eliminated when you see less money? I mean, that's really what we're going to be struggling with too, as a community.

MS. GRAUSE: So hospitals already today are -- you know, are cutting back on services like clinic hours and things like that in order to, again, bring those expenses back in line with existing revenues.

ASSEMBLYWOMAN PAULIN: So what are the kinds of services that we won't see in our -- probably in our most vulnerable areas?

MS. GRAUSE: Well, I think hospitals, just to answer it in a different way, they do everything possible to preserve ICU, emergency room, OR, all of that. That's core. But I think, you know, educational programs -- again, clinic hours -- are things that hospitals are looking twice at in order to reduce their expenses.

One of the things that we are seeing and that we are having many, many hospitals report from across the state is balance sheet erosion. So they -- month after month, their

expenses exceed their revenues, and they are -- their balance sheet is -- is eroding from --

ASSEMBLYWOMAN PAULIN: So I have one more question, and I'm going to squeeze it in.

MS. GRAUSE: Okay, go ahead.

ASSEMBLYWOMAN PAULIN: And it has to do with workforce. You know, the department is putting forward two initiatives, one to support compact inter-nursing, and the other is to support change in scope, you know, for PAs and other EMS and other areas.

Where do you fall on both of those two proposals?

MR. RASKE: Support them.

MS. GRAUSE: We support both, yup.

MR. RASKE: Absolutely.

ASSEMBLYWOMAN PAULIN: You want to elaborate a little bit on SED's concern about lack of supervision in terms of nurses in particular?

MS. GRAUSE: We don't think the data supports that. I think Acting Commissioner

McDonald said that there really is no quality concern.

And I think as far as scope of practice is concerned, the practice of medicine changes every single day. And I think taking a look at scope of practice in light of the shortage is long overdue.

ASSEMBLYWOMAN PAULIN: Thank you. My time is up.

Oh, sorry, we have one more Assemblymember. Assemblymember Byrnes.

ASSEMBLYWOMAN BYRNES: My apologies, I thought Mr. Jensen had told you. My apologies.

This will be very quick, and it's really a question to the entire panel, going back just for a second to the staffing shortages, which we all agree are profound.

Has there been any discussion yet as to the feasibility of rehiring workers that were fired simply for not getting the COVID vaccine, now that the pandemic is over? I asked the same question last year, I believe. And there are people who want to work that

were let go. They were healthcare heroes. Any discussion about allowing them to be rehired? Otherwise, great employees.

MS. GRAUSE: Under current law, they cannot do that because there is no allowance for a religious exemption. If that changes under state law, then I think hospitals would consider that. But currently, no.

ASSEMBLYWOMAN BYRNES: And that's because of the Governor's position.

MS. GRAUSE: Yes.

ASSEMBLYWOMAN BYRNES: Thank you.

ASSEMBLYWOMAN PAULIN: She's done. We are done.

CHAIRWOMAN KRUEGER: Okay, we are done.

ASSEMBLYWOMAN PAULIN: Thank you very much.

CHAIRWOMAN KRUEGER: Well, we clearly have far more questions, but we have to let you go. So thank you very much for your testimony today.

And our next panel will be the Primary Care Development Corporation,

Louise Cohen, and the Community Health Care Association of New York State, Rose Duhan. And unfortunately David Sandman from New York Health Foundation had to cancel.

But the testimony of everyone who has submitted testimony, whether they are testifying or not, has been distributed via electronic source to all Senators and 4, and is up on the web for anyone else in the State of New York to read at their leisure.

So shall we start with Primary Care Development Corporation?

MS. COHEN: Thank you for inviting us here today. My name is Louise Cohen, and I'm the CEO of the Primary Care Development Corporation, which is a community development financial institution and not-for-profit here in New York State.

Primary care saves lives, it improves individual and community health, and it's central to health equity. And it's the only part of the healthcare system that reduces health disparities and total healthcare

costs. Yet primary care gets only about 5 to 7 cents on the healthcare dollar -- not even half of what experts say it should.

Last year this Legislature passed the primary care reform commission legislation, which would have quantified primary care spending in this --

SENATOR RIVERA: Excuse me a second.

Folks, please take your conversations outside so we can hear the testimony. Thank you.

CHAIRWOMAN KRUEGER: Thank you.

MS. COHEN: -- would have quantified primary care spending in New York State and make recommendations to increase it. The Governor vetoed the bill, as you know, but the need for increased investment in primary care remains urgent.

The proposed Executive Budget offers several primary care enhancements which we support, but it falls short of more global changes needed to establish primary care as the centerpiece around which healthcare in New York State is designed. One of the

things we know from a recent report is that primary care spending in New York has decreased from 2016 to the current date.

We have three specific asks. The first is the Community Health Care Revolving Loan Fund, which was created by this Legislature in 2015 and administered by PCDC. It had an initial investment of $19.5 million to provide affordable loan capital for eligible primary care/behavioral health providers. It's now fully committed.

We ask that you infuse this fund with an additional $19.5 million, and that the fund's purpose be expanded to include debt refinancing and debt restructuring, both of which are critically important to the financial stability of community health providers in the current high-inflation, high-interest-rate environment.

And we support the Health Care Facilities Transformation Fund, but urge the Legislature to, as in years past, set aside a certain amount -- up to 15 percent at the least -- for primary care.

And in addition we want to let you know that the transformation fund is only reimbursable. What that means is community providers, particularly small ones, have to have upfront cash in order to actually build their facilities, and a number of grantees, therefore, have turned to PCDC and the revolving fund to provide bridge capital. And without the capital, the revolving fund and the transformation funds may well be unusable in this next year.

And I want to then, finally, about the 340B program, give a very distinct perspective from a community lender. As a community lender -- and we really lend to very grassroots community healthcare providers in New York State -- we can't consider one-year funds as substantial for an organization to take on debt. In other words, we can't lend to someone who says "I've only got this for a year," when the loan might be three years, it might be five or seven years.

So that's actually really important.

And we are a community lender; that is also true for banks. So what you're saying here with the 340B carveout, whether, you know -- and again, whether or not the state plan amendment goes through -- that that is a long-term problem for community health.

CHAIRWOMAN KRUEGER: Thank you.

Rose.

MS. DUHAN: Thank you, Louise. We agree with the comments that were just made by PCDC.

Good afternoon. I'm Rose Duhan. I'm the CEO of the Community Health Care Association of New York State. As the primary care provider for 2.3 million residents of New York State, 60 percent of which are covered by Medicaid, community health centers are foundational to improving population health and well-being through access to comprehensive primary care, dental care, and behavioral health services.

Community health centers provide care that is centered on health equity and reducing racial and geographic disparities in

health outcomes. Recognition of the importance of primary care included in the Governor's budget must be matched by an investment in community health centers.

Along with many of my colleagues that have already talked about this, we ask the Legislature to repeal or delay the pharmacy benefit carveout that will result in $260 million in losses across the health center network. Although the Governor's budget includes an administrative funding set-aside for health centers, an April 1 transition will result in an immediate loss of cash flow at a time when costs have escalated and competition for labor has reached crisis levels, as well as what was mentioned regarding the concerns of Medicaid redeterminations resulting in people losing their Medicaid coverage.

CHCANYS supports Senate 5136 -- thank you, Senator -- the alternative that would repeal the carveout while achieving many of the state's policy goals.

CHCANYS also requests the Legislature

direct DOH to work with community health centers to assess and redesign Medicaid payment rates based on the comprehensive model of primary care delivered by health centers, to bring reimbursement of health centers costs of care into the current century.

Health centers' reimbursement rates are based on costs from 1999 and 2000. A modernized payment basis, to be implemented in October 2024, is necessary to achieve the goals set in this year's budget for primary care.

The increases in Medicaid primary care rates in the Governor's proposed budget do not apply to community health centers, and rate reform, as was mentioned, is needed to ensure the primary care safety net is broad enough and strong enough.

Thirdly, we ask the Legislature to amend last year's enacted budget language related to telehealth parity, ensuring health centers are able to receive their full payment for audiovisual and audio telehealth

visits, regardless of patient or provider location, especially to protect access to behavioral health services.

Please refer to our written testimony for more comments. Thank you for the opportunity to testify, and I'm happy to answer any questions.

CHAIRWOMAN KRUEGER: Thank you.

Any Senators? Senator Rivera.

SENATOR RIVERA: Thank you.

I wanted to see if you could educate us about -- we've heard as far as -- certainly about 340B, we've heard about what, just in very vague terms -- very real terms, certainly. But I want to hear more specifically, what is it that you actually use those savings for? Could you give us some examples of some of the things that you would not be able to do were this program to -- were you not able to avail yourself of the program anymore?

MS. DUHAN: Yes. Well, I know that the Medicaid director mentioned I think a 250,000 number, which is people -- that may

be the number of drugs purchased with 340B. But as was mentioned, that's certainly not the number of people that are impacted by the use of these savings.

And one of the main purposes of these -- or one of the large, widespread uses of the funding is to purchase pharmaceuticals, to pay for prescription drugs for individuals who are uninsured. community health centers have an uninsured rate of about 13 percent, so about two and a half times the statewide rate of uninsured. And so that 340B funding is really critical to ensuring that people who are uninsured can have access to prescription drugs, to pharmacies -- to pharmacy services.

Health centers also use a lot of the funding for -- so to fund school-based health centers, something that really has been especially critical since children are returning back to school following the pandemic. A lot of unmet need, a lot of catching up on -- as was mentioned -- vaccines, and a lot of behavioral health

needs. So the school-based health centers are really critical in terms of ensuring that children have the full access to services that they need.

Additionally, a lot of outreach and care management. So ensuring that people understand what kinds of services are available, helping them to follow through with the care that they need, connecting them to a lot of the services that they would otherwise not be able to connect to.

SENATOR RIVERA: These would not -- you would not be able to do these things, or the centers that you represent would not be able to do these things if they weren't --

MS. DUHAN: That is correct. Many of these services are not reimbursed or reimbursable. Obviously, for someone who's uninsured, there is no payment. So 340B really provides the funding to support those services.

SENATOR RIVERA: Thank you.

CHAIRWOMAN KRUEGER: Thank you -- oh, I'm sorry.

MS. COHEN: No, if I could just say, we look at everyone's balance sheets as we decide about loans. And what we see is that there's an extraordinary difference between the revenue from reimbursement -- the 340B is unrestricted dollars that enables a health center to do, quite frankly, whatever they need to do in order to serve their patients.

And so these things that Rose mentioned I think are there. But let's remember that this is almost a form of value-based payment. We all want to give these organizations -- which have good outcomes, right? These are high-quality providers -- to be able to provide whatever service they think that person needs at that time. And these are really unrestricted dollars.

But we know from their balance sheets these community providers would actually not be able to survive, many of them, without it.

SENATOR RIVERA: Thank you.

CHAIRWOMAN KRUEGER: Excuse me for cutting you off.

MS. COHEN: Sorry.

CHAIRWOMAN KRUEGER: Assembly.

ASSEMBLYWOMAN PAULIN: Yes, I think I'm the only one.

Nobody questions the importance and need for primary care. What can we do -- or what can you do, what do you need, you know -- and resources, of course. But in terms of providing more access, in terms of providing more services, you know, what are those things that could be done that would go toward that goal?

MS. COHEN: So I think what's really important to recognize is -- you know, you just heard testimony that if a hospital is squeezed, the first thing they're going to do is close clinic hours. Right? That's the ambulatory care of a hospital. It's not their core function, but it brings patients in and it provides them -- they provide a lot of primary care in this state. But we also know that community health centers and independent physician practices do as well.

But there's actually large parts of

the state that actually have insufficient access to primary care. There aren't enough primary care providers, waits are incredibly long. And so what we think is an overall shift in the balancing of our healthcare system to really pay what other industrialized countries pay for them, which is 12 to 14 cents on the dollar, spread out among a lot of things.

So it's not just one thing. I mean, certainly we think it's sites. But it's also making sure that there's a robust workforce, making sure that hours are available for people who need to have off -- you know, off-work hours to see their providers. There's a whole host of things that it can be used for.

But at the end of the day, the four-to-seven -- you know, 4 percent on the dollar isn't even close to what we need. And we know that those things will be shuttered as these budget cuts happen, so --

ASSEMBLYWOMAN PAULIN: Are there -- is more needed in certain regions of the state

than in others?

MS. COHEN: So we did a report that we'd be glad to send around that showed where primary care access was limited in terms of the number of primary care providers.

There are certainly parts of the state that have actually very few primary care providers per population. So it's an apples and apples comparison. But we know that there are also pockets of real poverty, low-income communities that have been disinvested historically. And so those communities, we would argue, actually need more primary care than less. And that's true for rural communities as well as for urban communities.

So I think we try to use a couple of different metrics to look at whether there's sufficient access. But we would say in many parts of the city in New York City, and many parts of upstate, there are actually real pockets where there is just insufficient access. And that is one of the reasons why people do go to emergency rooms and why they

do have -- you know, have conditions that are -- need to be then treated either as an emergency or as --

ASSEMBLYWOMAN PAULIN: So just one final thing. If you were working for the Department of Health as opposed to being a recipient of funds from, you know, what incentives or what program would you put in place to expand that mission?

MS. COHEN: So I think it has to be in a lot of places.

So we applaud that the -- we think that the reimbursement needs to be raised. We need the overall investment in primary care to be much more than it currently is, both on the capital side and on the other side.

It's sort of looking at all the things. Like a workforce program should be -- there's a set-aside for primary care --

ASSEMBLYWOMAN PAULIN: We'll have to take that offline. But thank you so much.

MS. COHEN: Good question.

CHAIRWOMAN KRUEGER: Thank you.

I think just me. Oh, hello -- oh, no, you're for the Assembly.

ASSEMBLYWOMAN PAULIN: Oh, sorry.

CHAIRWOMAN KRUEGER: That's okay. Sorry.

So as I get older, I remember -- I used to study cost-benefit analysis in grad school, which was a hundred years ago, and --

MS. COHEN: That's when our rates were set, about a hundred years ago, yes.

(Laughter.)

CHAIRWOMAN KRUEGER: But I've also tried to keep up on reading even a hundred years later, and I'm pretty sure that the research shows that primary care is not only less expensive than hospital care, it actually decreases the number of people who need more expensive hospital care because they get sicker and then end up in the hospital.

Our policies seem to be in reverse in this state. Is that correct?

MS. COHEN: I think that's right. I mean, a recent California Healthcare

Foundation study showed that with larger investments in primary care, they saw better quality, better patient experience, and lower -- fewer hospital visits and emergency room visits and total cost of care. And they actually estimated that there would be billions of dollars in savings, even in the first year, if we rebalanced the healthcare system towards primary care.

I think the problem is when someone presents at the emergency room because they haven't been to primary care, you still have to take care of them. And so we see these -- we have trouble moving to sort of upfront prevention because it's hard to say, Oh, if you prevent one hospitalization, now you've downstream, you know, provided, you know, better health at fewer costs, because today what we see is what we see.

But we think that the primary care system is made up of hospitals, FQHCs, independent practices. No one should lose in this -- in this prospect. We want to see all these parts of the healthcare system build up

their primary care components, to Assemblymember Paulin's question, so that it's not just -- you know, it's not that there's a primary care system over here and the rest of the healthcare system over here. We think it's distributed.

CHAIRWOMAN KRUEGER: But there is data showing that if we had more primary care, particularly in the underserved areas you all are both talking about, that that would be actually, financially and healthcare-wise, a win for us.

MS. DUHAN: Yes. The healthcare centers spend a significant amount of their caregiving addressing chronic conditions, and if those kind of conditions aren't addressed, they progress, it becomes more expensive, it results in worse outcomes. So really the care that people provide -- the care the health centers provide makes the difference in terms of helping people manage their diabetes, helping people manage their hypertension so they aren't becoming sicker and then more costly.

MS. COHEN: But we can't do it by cutting costs of those providers today. You have to increase the primary care --

CHAIRWOMAN KRUEGER: I'm sorry that our third panelist couldn't be here with us, New York Health Foundation. But I hope that any studies that you are aware of that might verify what I believe would be very useful.

So thank you very much.

MS. COHEN: We hoped that the primary care commission that was vetoed by the Governor would have helped with that. But we believe that there's data that we can pull together and that we can forge a new approach to this, with your help.

CHAIRWOMAN KRUEGER: Thank you.

Any other Assembly?

ASSEMBLYWOMAN PAULIN: One more.

Assemblymember Jessica González-Rojas.

ASSEMBLYWOMAN GONZÁLEZ-ROJAS: Thank you both so much.

I was reviewing the testimony, and I understand that CHCs are not allowed to collect information on immigration status.

So you don't have a sense of the numbers of people who are undocumented --

MS. DUHAN: We do not collect -- health centers do not collect information on immigration status.

ASSEMBLYWOMAN GONZÁLEZ-ROJAS: Which I thank you for, for --

MS. DUHAN: Yes, for good reasons.

As I said, about 13 percent of health center patients are uninsured. And given the broad insurance coverage in New York State, we do think that the majority of that population is -- are people who are not eligible for insurance because of their immigration status.

ASSEMBLYWOMAN GONZÁLEZ-ROJAS: One of the things we're fighting for is to expand the Essential Plan. I saw that it was listed as a priority to insure that undocumented people are covered.

Can you talk about what that impact might be on your system? Actually, this is for both of you.

MS. DUHAN: Sure. Well, we estimate,

as I said, about 300,000 patients that there's no payment for, there's no reimbursement. So that would be -- having reimbursement for those patients would be a significant investment in health centers to allow them to continue to do the work that they do, to help them expand.

I think this is a time when we don't want to see health centers contracting. As we said, there's significant need throughout the state, and health centers would welcome the opportunity to serve more patients. They're seeing the need, both immigrant -- I mean, there's certainly been a very big influx of immigrant population with people coming in who need a lot of care, more care, more acute kinds of care, because they haven't had any access to services for a long time.

So having that reimbursement for those patients would make a big difference in terms of being able to really reach a broader population and ensure that people who need care can get it.

MS. COHEN: And I think you pointed out that New York State's going to pay for this one way or the other.

ASSEMBLYWOMAN GONZÁLEZ-ROJAS: Yes.

MS. COHEN: We're going to pay for it with emergency Medicaid or we're going to pay for it upfront.

I would argue that people will be healthier and it will cost less if we pay for it upfront.

ASSEMBLYWOMAN GONZÁLEZ-ROJAS: Thank you for that.

And also, Rose, you mentioned a population that I actually haven't heard all day, is children and school-based health centers. If you can just expound, in the 27 seconds you have, just to talk about what that would mean for our children.

MS. DUHAN: Yes, many of our health centers operate school-based health centers. And as I said, it's a critical point of access for children to get care from a broad range of services -- medical, dental, behavioral. Especially dental care; it's

really been critical. That's something that was postponed, along with many of the other healthcare services during the pandemic. So a lot of work to catch children up on the dental care that they need. And we -- that's a critical piece of the work that health centers do.

MS. COHEN: The Milbank Memorial Fund reported that in 2020 in New York State, 30 percent of children had no usual source of care. A usual source of care is really a school-based health center or a community health center or a provider -- a doctor in the community, pediatrician. That's really astounding and very concerning, I would say.

ASSEMBLYWOMAN GONZÁLEZ-ROJAS: Thirty percent -- I want to repeat that.

MS. COHEN: Thirty percent -- we can send you a link to the report, but it's 30 percent of children have no usual source of care in 2020.

ASSEMBLYWOMAN GONZÁLEZ-ROJAS: That's really concerning. Thank you for that.

Thank you.

ASSEMBLYWOMAN PAULIN: Thank you.

I just want to ask if -- Rose in particular, if you have a program or a proposal on rebasing that you could send us the information. When I say "us," to Helene and to the Senator here, and to Liz, and they'll get it to the rest of us.

MS. DUHAN: Absolutely. We'll be happy to share that with the chairs.

ASSEMBLYWOMAN PAULIN: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

So I think we've covered all the questions from people, so I want to thank you both very much for being with us today.

And our next panel: New York Lawyers for the Public Interest; New York Health Plan Association; Health Care for All New York; and Coalition of New York State Public Health Plans/New York State Coalition of MLTC and PACE Plans -- that is one group, I believe.

And for people who are following along, if you would like, you can head down closer to the front, Panel D, to be ready after Panel C: Medicaid Matters New York;

Empire Center; New York Association of County Health Officials; and Housing Works.

Good afternoon. Why don't we start at my left, your right, and just each introduce yourself and do your testimony.

MS. DUNKER: Thank you.

My name is Amanda Dunker. I am --

CHAIRWOMAN KRUEGER: Bring the mic closer so we can hear you, sorry.

MS. DUNKER: Thank you.

My name is Amanda Dunker. I'm here on behalf of the Health Care for All New York coalition and a director of health policy at the Community Service Society of New York, where -- it's on the steering committee for Health Care for All New York.

I wanted to start by addressing some comments we heard earlier about the 1332 waiver and the issue of covering undocumented immigrants and other people who are excluded from public health programs because of their immigration status.

So I think we heard earlier that the Department of Health was saying that they did

not include immigrants in that waiver because they felt that it might be rejected. Which we would argue we should ask and not anticipate a rejection.

I think another thing we heard is that they thought this $2 billion surplus would not be sufficient to cover the population that we're hoping to cover. So when you look at the waiver that's proposed, the rates in that waiver are already quite substantially higher than the current cost of the program, the Essential Plan. But even so, it still doesn't seem to add up to $2 billion or more. And that's not including offsets like the $500 million we'd save in emergency Medicaid, which I think other people have mentioned.

So in our estimates the $2 billion surplus would actually be sufficient to cover the 245,000 people.

And then our final comments are just if there's a concern that the money's not enough, the state has, for example, proposed capping the Medicaid buy-in program. We could consider capping this program if it hit

this $2 billion limit and just at least some people would get that relief instead of saying 911 can have the coverage.

There's obviously a lot of benefits to insuring more people, one of which is if your hospitals close. Another that is a priority for us is that insurance is the best way to prevent medical debt. Six percent of people in New York State overall have medical debt in their credit reports, but it's very high in a lot of places. Rural areas, rural counties in particular, experience really high rates of medical debt. In Chemung County, 27 percent of everybody who lives there has medical debt in their credit report.

And then if you look within some of our more urban counties like Onondaga County, it disproportionately affects people of color. So overall in Onondaga County it's 14 percent of people. But if you look at zip codes where most people are people of color, it jumps up to 26 percent of them have medical debt in their credit report.

So we are arguing that the hospital financial assistance law is one way to prevent medical debt. The Executive Budget proposal includes a change to that law that would create a uniform financial assistance policy at every hospital in the state, and then a uniform application. This would fix a lot of problems that we see that prevent people from getting the discounts that they should get, that they are eligible for under that law. Because we see a lot of applications that are not compliant with the law as it exists now.

So we're really excited -- is that time? Oh, okay, sorry.

CHAIRWOMAN KRUEGER: Thank you very much. Next?

MR. LINZER: Good afternoon. I'm Eric Linzer, president and CEO of the New York Health Plan Association. Thank you for the opportunity to testify today.

I'm going to highlight four items from our written testimony and requests that we have. First is our opposition to the

pay-and-pursue proposal, Part J. Second is our request to restore the funding to the Medicaid Managed Care Quality Program. Third would be our request to repeal the pharmacy carveout. And finally, our opposition to the proposed changes to the MLTC program in Part I.

On Part J, pay and pursue, this provision is opposed by unions, employers, health plans and others that are concerned about the affordability of healthcare in New York. The proposal would create a cumbersome and lengthy process that could take up to 10 months for plans to be able to recoup any payments that should not have been paid under this proposal.

I do want to address two comments that came up earlier today, one by the Medicaid director, who indicated that NYSHIP would not be subject to this. That's incorrect. NYSHIP and any municipality that gets its coverage through NYSHIP would be subject to this provision, so there would be a cost for both the state and municipalities.

And second, the comment by the Greater New York Hospital Association about the percentage of denials. Actually, quarterly data from the Department of Financial Services has indicated that the number of denials that occur actually -- you know, actually rule in favor of the health plan upon external appeal. So the comment that it typically rules in favor of the hospital is incorrect. We ask you to reject this proposal.

On the Quality pools, certainly we think this is essential. The Executive Budget, you know, eliminates the pools in their entirety, totaling about $110 million. These funds are utilized for critical programs including prevention, wellness, outreach to a very vulnerable, you know, population. And Dr. Schwartz is going to speak in more detail about it, but we would urge you to restore this funding as part of the final budget.

Third, you've heard earlier today about reversing the pharmacy carveout. We

agree with many of the -- with the comments that have been said about the importance of not allowing this to move forward. You know, but one comment that hasn't come up is really about the savings.

While the state has indicated that there would be about $420 million worth of savings, when the funds that get disbursed to various entities -- FQHCs, others -- it's really only about $42 million. We don't think this is sufficient, you know, savings for the level of disruption. Plus a Wakely analysis that we had commissioned last year indicated that it costs the state about $235 million annually.

And then, finally, you know, Part I of the managed long-term-care changes -- last year you may recall the administration tried to move forward with a procurement, and there's been discussion about the interim report. We would ask that before moving forward with this, there really needs to be a full analysis of that report.

CHAIRWOMAN KRUEGER: Thank you.

Next?

MS. ALBISTEGUI ADLER: Thank you for the opportunity to testify today.

SENATOR RIVERA: Closer, please.

MS. ALBISTEGUI ADLER: My name is Karina Albistegui Adler. I am here on behalf of New York Lawyers for the Public Interest and my undocumented and uninsured clients who face the worst of the things that could happen when you're uninsured.

At the outset, I'd like to emphasize how -- the urgency to pass the Coverage for All proposal, which in addition to the 1333 waiver -- I'm sorry, 1332 waiver -- also proposes to, if the waiver is denied, provide state-only-funded Medicaid coverage for immigrants in the same way that California has done.

For my clients, this is actually a life-and-death situation. Most of my clients find themselves in dire situations every day, choosing between paying for their food or medication or between working while they're feeling sick is a stark reality. While

emergency Medicaid does cover their dialysis, because many of them do -- most of them are on dialysis due to end-stage renal failure, they must pay upwards of $200 a month in prescription costs, many of them.

I'm going to share a story about one of my clients, Raul, who has faced this exact dilemma. Prior to the COVID-19 pandemic, he worked in the food service industry. He was a proud essential worker and continued to work through the pandemic until he became sick. Shortly after he recovered from COVID-19, his doctors told him that the COVID infection that nearly killed him had actually decimated his kidneys and he was now required to be on a grueling three-day-a-week schedule for dialysis.

He had to put everything on hold, including all of his dreams to become a chef. And he was also told, unfortunately, that because he is undocumented and uninsured, he would unlikely ever get a kidney transplant.

Raul and other undocumented New Yorkers like him exemplify a major moral

and ethical dilemma in our state. Many undocumented New Yorkers are registered organ donors, either through the New York State driver's license, NYCID, and also as {unintelligible} donors. And yet when they are in need of organ transplants, they are among the least likely to receive the transplants because of a lack of comprehensive health insurance.

I see many families desperately pleading with medical staff to help their loved ones when they're dying of organ failure, and of course they're told that they can't because they're undocumented and uninsured. Yet those same families often turn around and do donate a loved one's organs.

You know, we have the power right now to make the healthcare system more equitable for all New Yorkers. I invite you to also consider some interim steps to save lives and strengthen the commendable Living Donor Support Act passed last year. There could be a temporary measure to allow emergency

Medicaid to cover organ transplants.

Thank you.

CHAIRWOMAN KRUEGER: Thank you.

And last? You decided to take yourselves out of order for some reason.

DR. SCHWARTZ: Good afternoon, members of the joint legislative budget committee. My name is Dr. Tayla Schwartz. I'm president and CEO of MetroPlus Health Plan in New York City, and I'm here today representing the Coalition of New York State Public Health Plans, PHP, and the New York State Coalition of Managed Care Long Term Plans, MLTC, of which MetroPlus is an active member.

I will use my time here to highlight a few of the concerning budget proposals. The first one is eliminating the Quality Programs. The state's managed care and MLTC Quality Incentive Programs fund critical investments in provider quality and community-based initiatives that improve health outcomes and address social care needs for the state's most vulnerable populations, like the ones that we serve.

Plans rely on the funds to reimburse providers for high-value, evidence-based practices and support social drivers of healthcare interventions that are not otherwise covered by Medicaid.

As an example, MetroPlus has a dedicated housing unit which has supported members experiencing homelessness for the entire process of identifying them, the application, placement into supportive housing, and then ongoing support to make sure members remain successfully in their new home.

Despite the positive impact and significant value, the Quality funding has been consistently reduced over time and is now at risk of full elimination. We urge the Legislature to reject this step backward and support Senate Bill 3146, which would codify the Quality Incentive Program into law and ensure sustainable funding for what has become a powerful tool for driving high-quality and high-value care for the lowest-income residents.

Pharmacy carveout repeal. You've heard a lot about that today. Removing the pharmacy benefits from Medicaid managed care will harm Medicaid members. It will lead to massive confusion, gaps in medicine access and adherence, and fewer services from community-based safety net providers.

Further, along with other stakeholders, coalition plans have significant concerns about the state's ability to smoothly operationalize the carveout, given that it is slated to launch the same day as the start of the redetermination of Medicaid, CHP and EP eligibility for upwards of 9 million New Yorkers. MetroPlus Health alone is looking at approximately 50,000 redeterminations a month.

We urge the Legislature to repeal the pharmacy carveout and protect enrollees' access to needed medications and protect and sustain safety net providers.

And finally, the Executive Budget also includes a highly disruptive proposal that

would substantially upend MLTC coverage for elderly or disabled New Yorkers. This proposal, which would require MLTC plans to meet minimum enrollment thresholds and give the health commissioner sole discretion to trigger a plan procurement, would winnow the market down to just the largest MLTC plans and essentially will eliminate MLTCs upstate.

Thank you for your time.

CHAIRWOMAN KRUEGER: Thank you very much.

Our first questioner will be Gustavo Rivera.

SENATOR RIVERA: Hello, folks. This is for Ms. Dunker and Ms. Albistegui Adler. I want to dig a little bit deeper into what was said earlier, and I want to make sure, Ms. Dunker, that you speak as closely to the mic as possible, because indeed it seems to me that you said, in response to the claim this afternoon -- earlier today from the Medicaid director, that we could not seek the waiver that would -- that could actually, you know, make it so that we can afford to do

this, right?

What is your response to what you heard this morning? Say it to me again, please.

MS. DUNKER: Well, first of all, we should ask instead of anticipate being rejected.

Second of all, we haven't seen the math either on the estimate that they said --

SENATOR RIVERA: Oh, you haven't seen the math.

MS. DUNKER: No. So that's the first time that we've heard that --

SENATOR RIVERA: I know you're shocked. I'm shocked. We're all shocked. Yeah, go ahead.

MS. DUNKER: But just the information we have, it doesn't -- we haven't seen an estimate that it would cost $2 billion or more than $2 billion to cover the number of people we're talking about, which is about 245,000.

SENATOR RIVERA: Okay. And then the -- one of the things I asked about was

about emergency Medicaid and about the amount of money that we use now. And this would actually -- could this avert that cost if we are able to do this?

MS. DUNKER: Right. So this emergency Medicaid cost would actually go away completely because that population would have comprehensive, real health insurance instead of emergency Medicaid, which only covers, you know, certain conditions in certain emergencies.

SENATOR RIVERA: Thank you for that.

And just to reiterate from the experiences of some of the folks that I figure that you folks represent, who are on -- who don't have any type of coverage, anything else that you'd like to add as far as how essential it is for the populations that you help out every day?

MS. ALBISTEGUI ADLER: Yes, thank you.

For our clients, it's really, truly a life-or-death situation. Being on dialysis, which is covered by emergency Medicaid, actually results in poorer long-term outcomes

as compared to transplants. And because they are barred from transplants, you know, this could really have a major impact on their longevity and their ability to participate in our communities.

SENATOR RIVERA: Thank you both.

MS. ALBISTEGUI ADLER: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Assembly.

ASSEMBLYWOMAN PAULIN: Assemblyman Jensen.

ASSEMBLYMAN JENSEN: Thank you very much, Madam Chair.

This question is going to be for Mr. Linzer. Going back to the very first panel, there was some conversation, I asked questions about the health guarantee fund. From your understanding of that proposal, would these new assessments or taxes, whatever verbiage, apply to large, self-funded accounts?

MR. LINZER: The short answer is no.

I mean, the superintendent was correct earlier today when she said that it would

apply proportionately to fully insured health plans. Those who typically purchase fully insured are usually small, midsized businesses. We think that this would have a disparate impact on many of the upstate plans, first.

But second, I think it begs the question of if there are concerns about the long-term-care insurance marketplace, it raises questions as to why health insurance consumers should be the entities that end up paying for these assessments.

ASSEMBLYMAN JENSEN: So it's your understanding, if it's going to be the small businesses, the businesses who are having -- requiring this coverage, and the other fully insured businesses, they're going to be the ones that end up paying more if this fund were to be put in place.

MR. LINZER: It certainly would be them as well as any fully insured municipality or, you know, larger-size employer.

So it certainly, I think, given -- you

know, given the concerns about, you know, taxes, assessments, the $6 billion related to HCRA and other assessments that get applied to health insurance -- and recognizing that this wouldn't get triggered until there is an insolvency -- it does raise concerns about the prospect of asking health insurance consumers, as well as employers, union benefit funds and others that are fully insured, to have to bear the cost of any kind of shortfall or insolvency in the long-term-care market.

ASSEMBLYMAN JENSEN: So in your role at the association, do you believe that DFS already has the tools in place, through statute and policy, to protect consumers and providers in the event that a health insurer does become insolvent?

MR. LINZER: There are certainly protections in place. You heard the superintendent earlier today talk about steps that they have in the event, you know, a provider or a health plan gets into, you know, financial trouble.

There's also the approval rates. You know, on the front side of the process, if rates are actuarially sound and approved to recognize the full cost of care -- doctor visits, hospital stays, increases in prescription drug costs, as well as taxes, fees, and assessments -- then as long as the premiums are actuarially sound, that provides -- that should provide sufficient protection on the front end.

ASSEMBLYMAN JENSEN: Do you agree with the urgency of the Executive to put this in the budget?

MR. LINZER: I mean, given that it doesn't have a fiscal implication, you know, our preference would be to see this taken out of the budget and certainly have, you know, other conversations outside the budget process.

ASSEMBLYMAN JENSEN: Okay. Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Senator Webb.

SENATOR WEBB: Thank you, Chairwoman.

And thank you all for being here.

So my question is actually directed to Health Care for All New York. And so, Amanda, I was wondering if you could expound upon your mentioning with regards to medical debt. As someone that represents a very both rural and urban, suburban district, this is probably one of the most prominent things I've heard in the work that -- most certainly I've worked with Health Care for All New York in the past.

So I was wondering if you could expound upon what else can we do to take steps to address medical debt for New Yorkers?

MS. DUNKER: So one is to make sure that people are getting financial assistance when they're eligible for it. That is -- right now that is limited to people who earn up to 300 percent of the federal poverty level.

Like I said before, there's problems with some of the policies and applications. It's very hard for people to apply. So the uniform application that's in the

Executive Budget already I think would help a lot more people get access to these discounts and help prevent medical debt.

We are also hoping, though, to do more to reform the financial assistance law, I think most importantly to change the income thresholds, the eligibility thresholds, to match all the other healthcare programs that we have. So right now you can get, for example, premium subsidies to buy health insurance, up to 600 percent of the federal poverty level.

The difference is in all of the thresholds between this program and other ways that we help people get healthcare is a problem in making sure people know that they're eligible, because it is just so confusing to have it be so different.

SENATOR WEBB: Okay, thank you.

And then my next question deals with consumer assistance. I previously had done work as a facilitator, enroller, for Family Health Plus and Child Health Plus and Medicaid. And so my question is with regards

to the outreach proposal that you all talk about, can you just expound upon what that outreach could look like as it pertains to doing outreach in communities that have high rates of uninsured people?

MS. DUNKER: So this is in regard to the navigator program, which helps people enroll in health insurance. And like I said before, that's the best way to help prevent people from having medical debt, is insurance.

So the navigator program does not get funding to do outreach in places where we know that a lot of people have not enrolled in health insurance but might be eligible for programs that already exist. So we think that it would be -- it would help if we could have a grant program to community-based organizations, which is already how the program works.

We provide services in every county in the state, and that those grants go out to community-based organizations that are familiar with the area and that people trust.

And so we're proposing that we have a $5 million grant program that would be specifically focused on outreach to those communities where more people than elsewhere are uninsured.

SENATOR WEBB: Okay, thank you.

CHAIRWOMAN KRUEGER: Thank you.

Assembly?

ASSEMBLYWOMAN PAULIN: Yes.

Assemblymember Gandolfo.

ASSEMBLYMAN GANDOLFO: Thank you, Madam Chair.

I have a question for you, Mr. Linzer. I believe you indicated that the pay-and-pursue portion of the budget, Part J, that it would make coverage more expensive for consumers, union benefit funds, employers and the state employee benefit program. Can you talk about that a little bit and expand on how it would increase the costs?

MR. LINZER: Sure. So as I said in my testimony, what this would create would be a lengthy and cumbersome process that plans would have to pay first and then pursue and

chase any kind of clinical documentation to determine whether or not the services were medically necessary.

Under the current process, providers today have 120 days to submit claims. Plans then have to pay within 30 days if it's electronic, 45 days if it's paper. If plans require additional information, then they have 15 -- they have to make that request during that 30-day period and, within 15 days of receiving that information from the provider, make a determination. So you have a compressed time frame.

Here, under Part J -- and we included it in our testimony -- you have a multi-step process that could take up to 10 months before a plan would be able to recoup any kind of payments that shouldn't have been paid in the first place, whether it was for -- it was determined that services weren't clinically appropriate, incorrect billing, or other related issues.

I think the thing that's gotten lost in this whole conversation is this is not the

health plan's money. But this is also not the hospital's money. This is the employer's money, this is the consumer's money, this is the labor union's money. And for them to then have to wait, first to pay out for something that may or may not have been clinically appropriate, you know, then to have to recoup that, adds additional cost to the whole system.

But the other piece is this -- you know, while the superintendent earlier today talked about this being a test case and improving efficiency, I think we wonder how adding -- you know, creating a 10-month process in order to determine whether or not -- and recoup any in correct payments, you know, creates a more efficient process, particularly for -- you know, at a time when we're trying to make the system much more simple and more affordable for employers, consumers, union benefit funds, and others.

ASSEMBLYMAN GANDOLFO: And so will this proposal have any impactful benefits to the patients themselves? How will this

impact the average consumer?

MR. LINZER: We think, you know, it's questionable at best. I mean, you know, the fact that you have to, you know, pay for clinical care or pay for services that may not have been clinically appropriate, you know, creates the potential for unnecessary testing and procedures to then have to chase after the fact.

And it, you know, I think creates a disincentive for providers to follow best practices. So at a time when, you know, there's already issues and challenges related to quality, paying for services that aren't clinically appropriate, and then having to chase that and recoup over a 10-month process, you know, is not the best use of limited healthcare resources.

ASSEMBLYMAN GANDOLFO: All right. Thank you very much.

CHAIRWOMAN KRUEGER: Thank you.

Are there any other Senators? Nope -- oh, wait.

SENATOR RHOADS: Just one.

Just a -- Steve Rhoads. Just a question for Mr. Linzer.

The proposed budget includes $125 million in state funding for 340B providers to what they claim to offset losses that they'll incur under the pharmacy carveout. Is that an accurate figure?

MR. LINZER: You know, as I said in our testimony, you know, the concern that we have, in addition to all the quality issues, the disruption to patients, particularly individuals with acute and chronic conditions, as well as the impact this is going to have on the delivery system -- we, you know, question the numbers.

I mean, while the state's estimate of savings of $420 million that then gets redistributed to different entities, results in, you know, really $42 million in net savings for the state. However, we had the Wakely Consulting Group take a look at the -- do its own analysis on behalf of our industry back in December to look at the potential cost impact. Their estimate was that the

move to carve out the benefit from managed care would actually result in an increase in state costs of about $235 million annually.

So while that may not directly answer your question about individual components of it, I think there is a legitimate disagreement among parties as to whether or not this is going to truly generate meaningful savings while at the same time, as Dr. Schwartz had indicated earlier, you create significant disruption in the system for patients and providers.

SENATOR RHOADS: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Assembly.

ASSEMBLYWOMAN PAULIN: Yes, thank you.

Assemblymember Palmesano.

ASSEMBLYMAN PALMESANO: Good afternoon. My question is for Mr. Linzer.

You touched on it a little bit in your opening remarks, and I wanted to kind of get into the issue of the elimination of the Quality pools, if I may.

What do the healthcare plans right now

spend the Quality pool dollars on now? And what programs might be actually negatively impacted by cutting of these funds?

MR. LINZER: So I'm going to probably defer most of this to Dr. Schwartz.

Just at a high level, those Quality pool dollars get utilized for a number of services like preventative screenings, in-home wellness services, and others that directly benefit patients as well as support providers.

But Dr. Schwartz?

DR. SCHWARTZ: Sure.

So the majority of the funds actually are going to the providers, incentivizing the providers to provide standards of care.

Additionally, those dollars are being used for services that are currently not covered by Medicaid, such as assistance with homelessness, assistance with food insecurity.

Those dollars are also used for outreach for members who are not adhering to preventative care. So women who are not

getting their mammograms as recommended or other preventative care, there are significant efforts to reach out to those members to make sure that they actually receive the appropriate treatment.

And so without those dollars, all of those efforts will not have sufficient funding.

ASSEMBLYMAN PALMESANO: I just have one more question.

It's my understanding -- obviously New York has ranked consistently high in quality on a national scale. What will loss of this funding in health, from your perspective, how will it affect those metrics when we look at it nationally?

DR. SCHWARTZ: Yeah, I mean, we made significant progress closing the gap between the underserved population and the commercial population. There was a significant gap, and then it was closed because there was investment in quality.

With those dollars and the funding going away, there is a real concern that the

gap will reopen. And so the services that are currently being rendered to the underserved populations will be actually reduced.

ASSEMBLYMAN PALMESANO: Thank you very much.

CHAIRWOMAN KRUEGER: Thank -- oh, no, we have 54 seconds. Nope? Okay. Any other Assemblymembers?

ASSEMBLYWOMAN PAULIN: Of course.

Assemblymember Jo Anne Simon.

ASSEMBLYWOMAN SIMON: Of course. Thank you, Madam Chair.

So, Mr. Linzer, I have a question. You know, we've talked a lot about home care in this hearing. And as you know, there were -- we just increased it to $30 an hour last year, and it also set benchmark rates that plans were supposed to pay for home care to pay for associated costs -- payroll taxes, et cetera.

But the Times Union's reporting that private insurance companies are offering pay bumps as low as 20 cents to 50 cents an hour,

according to two insurance companies.

So my question is, in exact dollars, how much money did your members keep this year and how much did they pay to the home care providers?

MR. LINZER: I don't have specific information on what the plans individually may have kept or sent out.

What I can tell you is that the plans have worked in good faith with various agencies to ensure that those dollars flow. I think there is some -- you know, some difference in -- and level of confusion as to how those dollars have been, you know, sent out to home care agencies.

I think the thing to keep in mind here is particularly with that Times Union story, you know, one, I think, you know, there wasn't any kind of clarity as far as any additional dollars that those plans may have provided in advance of the minimum wage bump at the beginning of October.

And we did have plans that prior to that had increased the -- their payments to

those agencies out of a recognition of the concerns we heard earlier today about workforce challenges. And without the -- you know, we recognize, without those workers, we don't have a network or the ability to serve our members. So it's in the plan's interest to make sure that those dollars flow through.

I think where the challenge comes in is, you know, there's really a lack of accountability and transparency in the bulk of the healthcare industry. As you heard from the Medicaid director earlier today, plans are subject to regular and routine audits by both DOH as well as OMIG to look, investigate, and to ensure that those dollars flow and flow and support medical services.

ASSEMBLYWOMAN SIMON: So, you know, there is a particular benchmark rate set for downstate and upstate. Do you know how many of your members actually paid those benchmark rates?

MR. LINZER: We can follow up with you on it.

ASSEMBLYWOMAN SIMON: Can you, please?

MR. LINZER: We did -- we did ask our members on the downstate provision, and many, you know, were significantly above the mean. You know, the upstate data we are still collecting and hope to have that. But certainly we'd be happy to follow up with you in more detail on this.

ASSEMBLYWOMAN SIMON: Thank you. Because we'd love to have it before we get into the budget finally.

Thank you.

CHAIRWOMAN KRUEGER: Okay. Any other Assembly?

ASSEMBLYWOMAN PAULIN: Yes. Assemblymember Jo Anne Simon. Oh, she just went. Sorry about that.

Nikki Lucas.

ASSEMBLYWOMAN LUCAS: Hello? Okay, great. Thank you, Madam Chair.

So I have two parts, if I can squeeze them in. New York Lawyers for Public Interest, in your testimony you mentioned that the State of New York should provide comprehensive healthcare coverage to all

residents regardless of immigration status, including coverage for organ and tissue transplant. This could have a major financial impact on the state budget.

Two things. One, what will be the total financial ask to achieve this request? Forgive me if it's been asked already. And also, you also mentioned that the State of California is about to provide this, beginning in 2024. Can you provide us on what the State of California did to achieve this, and the financial impact the state will be contributing to their plan?

MS. ALBISTEGUI ADLER: Thank you so much for that question. I think my colleague from CSS might have some better numbers, but I can tell you that that was referring to the Coverage for All proposal, which would essentially not be at a cost to New York State. It would be a savings for the state based on, you know, moving from emergency Medicaid to full coverage.

The State of California, I'd be happy to get you that information later. We do

cite the -- you know, that proposal, and it should be going into operation in 2024. But I believe it is an expansion of their state-funded Medi-Cal program, which we can also do in New York State.

ASSEMBLYWOMAN LUCAS: Okay, great.

I want to squeeze this in. This was for an earlier panel, but I believe someone can answer this, that -- delaying the expansion of Medicaid coverage for qualified New Yorkers over the age of 65 who are currently ineligible due to immigration status.

What would be the cost to the New York taxpayer? Do you have a breakdown of how this will impact New Yorkers financially? And is the 65 or over your only determining factor for qualifying? This was for someone earlier. And then what mechanism or methodology do you use in this approach? And last question, how does it impact home health aide workers?

MS. ALBISTEGUI ADLER: The expansion for the people who are 65 and older has

happened, but it hasn't been implemented. So I don't quite understand the reasoning why that hasn't occurred. I think there was some systemic -- system-ic, actually, tech issues about moving people over.

And we'd be happy to get you more information on the figures as we understand them.

ASSEMBLYWOMAN LUCAS: That's your answer to all the questions?

MS. ALBISTEGUI ADLER: Pardon?

ASSEMBLYWOMAN LUCAS: Is that your answer to all of the questions?

MS. ALBISTEGUI ADLER: Um --

ASSEMBLYWOMAN LUCAS: I guess so.

MS. ALBISTEGUI ADLER: I'd be happy to --

CHAIRWOMAN KRUEGER: You'll have to take that offline.

ASSEMBLYWOMAN LUCAS: I appreciate that. Thank you.

ASSEMBLYWOMAN PAULIN: All right, thank you so much.

Assemblymember Jessica González-Rojas.

ASSEMBLYWOMAN GONZÁLEZ-ROJAS: Thank you, particularly to Karina and, I'm sorry --

MS. DUNKER: Amanda.

ASSEMBLYWOMAN GONZÁLEZ-ROJAS: Yeah, Amanda. Thank you to your points about Coverage for All. This has obviously been a priority for me, and I thank you for all your work on this and making the case, because it could save us so much and also improve health equity in the state.

However, I do want to ask the Plan Association about wage parity. The CDPA was added to the wage parity to address the issue of some home care agencies shifting Medicaid members from traditional home care to CDPA, but failing to abide by the rules of CDPA, which require consumer-directed care, and failed to support an appropriate pay scale.

So given the wage-parity law -- that the wage-parity law mitigated this problem, what is the rationale for the Governor's proposal to eliminate wage parity? And how does the budget address the risks that wage parity addressed?

MR. LINZER: I'm going to have to follow up with you on what impact. We haven't -- you know, we haven't modeled or analyzed that issue.

I mean, again, we certainly recognize the importance of ensuring that, you know, individuals receive the funding that they're owed and deserved. But certainly would have to follow up on that because it's not an issue where we've taken an active position.

ASSEMBLYWOMAN GONZÁLEZ-ROJAS: That's all. Thank you.

ASSEMBLYWOMAN PAULIN: Thank you.

Assemblymember Anna Kelles.

(Discussion off the record.)

ASSEMBLYWOMAN KELLES: There we go. Can you hear me?

MR. LINZER: We can.

ASSEMBLYWOMAN KELLES: Okay. So following up on the discussion on plans, can you talk to us about -- can you hear me?

CHAIRWOMAN KRUEGER: Speak louder if you --

ASSEMBLYWOMAN KELLES: Okay, can you

all hear me now? Lovely.

Can you talk to us a bit about the breakdown of where the money goes, of the money that the managed care providers -- the MCTs keep?

MR. LINZER: So as you heard from the Medicaid director earlier today, there is a medical loss ratio that requires right now 86 percent of the premium dollar gets spent --

ASSEMBLYWOMAN KELLES: Correct. The remaining 14 is what I'm asking for. What's the breakdown of what that goes to?

MR. LINZER: We would have to follow up on -- you know, collectively. But to give you a general sense, you know, first there are administrative components. So you've got, you know, things such as network development; member outreach, as Dr. Schwartz had indicated; claims payments, IT operations. And, you know, so those types of components that come into play with any health plan, having to make sure that the claims that come in get paid, operational

challenges. Obviously --

ASSEMBLYWOMAN KELLES: Could you provide us -- because we have no oversight. If you could provide us a breakdown of where that money goes.

MR. LINZER: Sure. So it's certainly --

ASSEMBLYWOMAN KELLES: Because we pay billions of dollars that go specifically -- those 14 percent, and we don't see any of that breakdown. I'd love to see it, including like salaries, maybe broken down into sort of --

MR. LINZER: We'll give you what we're able to give you. I think one of the pieces that you might be, you know, looking to get at as far as surplus or profit margins -- you know, these plans operate on very, you know, slim margins, typically in the 1 to 2 percent range.

And there are, you know, standards that the department puts in place limiting how much plans can make. Typically a good year for any health plan is going to be, you

know, roughly a 1 to 2 percent profit margin. But there are also years where plans will be in the red and have their medical costs be in excess of, you know, 86 percent.

ASSEMBLYWOMAN KELLES: That would be great to see the breakdown of that --

MR. LINZER: Sure, and we'd be --

ASSEMBLYWOMAN KELLES: Over a few years, just to give us a sense that --

MR. LINZER: Sure, we'd be happy to do that and certainly would, you know, welcome the opportunity to sit down with you face to face and talk in more detail about this.

ASSEMBLYWOMAN KELLES: Thank you.

ASSEMBLYWOMAN PAULIN: Thank you.

I think I'm the only one left, and I just have two questions.

First, how many MLTC plans do you think are needed to have statewide coverage and member choice?

MR. LINZER: We haven't taken a position, Madam Chair, as far as the number or what the right number is.

Like there is a recognition, you know,

as part of last year's conversation, around Part P and the Medicaid procurement, and this year with Part I, that there is consolidation taking place in the market. I think there needs to be a recognition of ensuring that -- as -- you know, in ensuring that there's coverage throughout the state.

I think a lot of discussion focuses on the downstate, but recognizing that there are different and unique challenges in the upstate market. But also recognition that when a -- if a plan were to go away, either as a result of a procurement and not being chosen -- you know, the state had that experience with GuildNet just a few -- you know, maybe about seven or eight years ago or so, and that was a 9,000-member plan. But there was significant disruption just for, you know, that small segment of individuals and a lot of work that goes into coordinating their services, moving from a new plan.

So while I don't have -- you know, couldn't give you what an appropriate number would look like, there is a recognition that

there is consolidation taking place in the market already.

ASSEMBLYWOMAN PAULIN: And finally, you know, why the Wakely report, UCMS 64 reports from 2017 to estimate state supplemental rebates they would receive under the carveout, versus more recent reports that show a much higher supplemental rebate amount?

MR. LINZER: I'm sorry, say that again?

ASSEMBLYWOMAN PAULIN: So in other words, the reports that were used to estimate state supplemental rebates came from 2017. And the more recent data might have been more appropriate. I just wondered your thoughts.

MR. LINZER: I think the -- you know, Wakely tried to utilize the most recent publicly available data that they were able to access, and then made certain assumptions, you know, extrapolating out from that.

ASSEMBLYWOMAN PAULIN: Okay, thank you. That's it for me, and I think everyone.

CHAIRWOMAN KRUEGER: So we are closed.

Thank you very much for your testimony; appreciate it.

And our next panel we did ask to come up a little earlier: Medicaid Matters for New York; Empire Center; New York Association of County Health Officials; and Housing Works.

And Panel E, which will follow them, if you want to also get in a little closer to make your run up to the panel afterwards -- I'm just kidding about running -- LeadingAge New York; New York State Health Facilities Association; and Long Term Care Community Coalition -- will be the following panel.

And shall we start on my left, your right. You'll introduce yourself, you'll do your three minutes, and we'll keep going down the line.

DR. GELMAN: Sounds good.

Good afternoon, Chairpersons Krueger and Paulin, Senator Rivera, and honorable committee members. Thank you for this opportunity to present the state budget priorities of New York's 58 local health

departments.

My name is Dr. Irina Gelman, and I currently serve as president of the New York State Association of County Health Officials in my role as commissioner of health for Nassau County.

Entering this budget session we see the Governor has prioritized several public health policies that we support, as we believe they will better protect New Yorkers. However, without the fiscal commitment and resources our local public health workforce needs to take action, these policies will remain impossible to implement. Strong public health policy is policy that is appropriately funded.

A case in point. The Executive has provided for preventive lead funding in the budget proposal. However, with only 18 million placed in the State Operations section of the proposed Executive Budget, it fails to account for or support the work localities will need to conduct at the local level to maintain an inspection registry.

There is no doubt that we must shift focus toward a prevention-based model. However, due to a 2019 unfunded mandate and an administrative cut to lead funding which impacted 12 counties, it is imperative that this policy -- and others we are implementing to protect children -- are fully funded in the enacted budget.

We urgently request your support by increasing the lead funding appropriation in your one-house bills from 18 million to 58 million and, further, moving appropriation to the lead poisoning prevention program under the Department of Financial Services budget.

The Governor also has proposed a strong tobacco control package that NYSACHO encourages the Legislature to retain, with specific amendments that are outlined in our full written testimony.

Despite New York removing flavored e-cigarettes from the market, menthol cigarettes, flavored cigars, and flavored hookah are still available for purchase.

Flavored products are marketed by the industry to communities of color, LGBTQ+, and low-income communities, and flavored products hook kids on nicotine.

The existing ban on flavors has been challenging to enforce on retailers locally. I want to clarify that enforcement the localities provide is civil in nature and only directed at retailers. In no way, shape or form is there or should there ever be enforcement action against consumers. This is very simply about protecting children from the harms of exposure to these products.

Further, we respectfully request that you include language in the cannabis statute that mirrors the New York State Public Health Law ban on flavored tobacco products to ban flavored aerosolized and combustible cannabis products and impose clear marketing and packaging requirements for cannabis retailers that are specific as to what products can be named. This will assure a consistent standard for aerosolized and combustible products throughout the state.

Please note that your local health departments are here working tirelessly, around the clock, to protect constituents in your districts from public health threats.

Thank you for your continued leadership, support and attention.

CHAIRWOMAN KRUEGER: Thank you.

Next?

MS. KASSEL: Good afternoon. My name is Lara Kassel. I am the staff coordinator to Medicaid Matters New York. Medicaid Matters is the statewide coalition representing the interests of people who have Medicaid for their health insurance coverage.

I appreciate the opportunity to address you today, and thank you for being here. Thanks also to your staff for being here as well.

Medicaid Matters has been around for 20 years. We are celebrating our 20th anniversary this year, our 20th year of bringing the voices of people who are covered by Medicaid to these tables.

I want to take a moment to illuminate

the importance of Medicaid by reading some quotes that we have collected as part of our work. We use them with permission.

"Medicaid has been a lifeline and has been life-altering, particularly in terms of my reproductive care. Not only that, but it's also helped empower me as a person."

The second one: "I'm anemic, and I discovered that I was able to get iron infusions through Medicaid coverage. Through these iron infusions, and then being able to take care of my gynecological issues, I felt that I could be a better parent and caretaker for my child."

And then, lastly: "Because of Medicaid, I was able to get single-fiber electromyography testing" -- a mouthful -- "testing performed which confirmed that I had a rare subtype of an autoimmune neuromuscular disease. Left undiagnosed and untreated, the survival rate is not good. Medicaid literally saved my life."

This year's budget represents, as it always does every year, an opportunity to

improve on the Medicaid program and the lives of the people who are covered by the program. Sadly, however, this year's budget does not go nearly far enough to do that, despite the administration's stated intentions to reach greater health equity.

I see that I'm running short on time already. You have my written testimony, and I will just mention a few things that you'll find in our written testimony.

You can play a part in making some of these changes and improvements to the program by enacting Coverage for All, by enacting Fair Pay for Home Care, by ensuring that Medicaid dollars are allocated to true safety net institutions. With the many discussions about increasing Medicaid rates for large institutions, there must also be commensurate focus on doing the same for community-based providers that meet people where they are.

Raise the asset limit to provide more equitable access to the program for older people and people with disabilities. Provide continuous coverage from birth to age 6. And

lastly -- but certainly not least -- infuse transparency into Medicaid and all of its programs by requiring more data collecting and reporting.

Again, you have my written testimony, and I'm happy to answer your questions.

CHAIRWOMAN KRUEGER: Thank you.

Hi, Bill. Next?

MR. HAMMOND: Good afternoon. My name is Bill Hammond. I'm senior fellow for health policy at the Empire Center.

We've heard a lot today about the ins and outs of the Medicaid budget and the details, and an awful lot of groups who feel like they're not getting the money that they need or they're actually being cut. I think it's important in this context to step back and look at the big picture.

New York spends an extraordinary amount of money on this program. It's set to break $100 billion this year, including all sources of revenue. Heading into the pandemic, we were spending more per capita than any state. And since the start of the

pandemic, we've increased the state's share of the program by 20 percent, and this year's budget would add another 9 percent on top of that. Those are much faster rates of growth than we have been accustomed to over the previous decade.

And the only reason that we've been able to make that kind of spending increase is because of these temporary sources of funding -- temporary federal aid and a surge in state revenue, which is -- I mean, history teaches us is not going to last.

So the question -- the important thing is to run the program in a sustainable way. As we've just heard, it's an absolute lifeline for many New Yorkers, and so it's important to be responsible in managing it. It's kind of like an ocean liner -- if you get going too fast, it becomes all that much harder to steer away from the icebergs.

So I think in that context there are a number of proposals that the Governor made which would actually make things more affordable, which I think deserve support.

And those include things like repealing "prescriber prevails" in the Medicaid program, reducing indigent care funding to the low-need hospitals, loosening scope of practice limits on professionals such as nurses and pharmacists, and joining the Interstate Medical Licensure Compact.

There are a number of other proposals that I think should be rejected or revised. The idea that you would increase costs for local governments, I think that should be a red flag that those costs are out of control. Because if the state is dramatically increasing its spending on Medicaid and it's asking the localities to increase their contribution, that's a sign that costs are out of control.

I think you should really think hard before extending the HCRA surcharges. Those are a $5 billion tax on health insurance, 6 billion in total revenue. That only makes health insurance less affordable and drives more people into public programs.

I would argue that you should reject

the pharmacy benefit on the grounds that you don't want to make the system more fragmented than it already is. The managed care plans should have a holistic view of their clients.

And the cigarette tax I don't think is advisable. It's going to drive more people into the black market. And also I would reject pay and pursue.

Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Charles?

MR. KING: Hi. Charles King, representing Housing Works and the Ending the Epidemic Community Coalition.

I want to thank Senator Krueger for inviting me back to testify after my arrest in this same space earlier today. I understand that not everyone on this panel appreciated our action this morning.

However, what I would point out to you is that this Legislature actually two years ago approved the carveout of pharmacy from managed care -- and, even after we made very clear to you the impact of this carveout on

the beneficiaries of services from Federally Qualified Health Centers and Ryan White care providers, did nothing about it last year. And that is why we are adamant that the Legislature take action this year.

We strongly support the bill by Senator Rivera and Assemblymember Paulin that would address the Governor's concerns around transparency and cost variations.

I also want to address the issue of Health Home. Not only is the Governor cutting $100 million out of this program over two years, but even more insidiously, is intent on rolling 70,000 participants off of the program by putting in time limits of nine months and 12 months, depending on your classification, without any clinical assessment of your health circumstances or your psychosocial needs.

I also want to raise the issue of 1332 in the context of HIV by making you aware that right now, even though we are dramatically decreasing the number of new infections of HIV across the state, what we

are seeing is a rise in people receiving their HIV diagnosis simultaneous with receiving a diagnosis of AIDS. Far too many of these folks are undocumented immigrants who, because they have no health coverage, only go into the emergency room when they're facing a life-threatening situation which all too often is an AIDS defining circumstance.

I would also like to address the issue of overdose prevention centers. There is a bill introduced by Senator Rivera and also by Assemblywoman Rosenthal that would authorize and fund overdose prevention centers. In 2021, over 6,000 New Yorkers, mostly low income and people of color, died of drug overdose because they don't have access. The two overdose prevention centers that presently exist, over the last 14 months saved more than 250 lives.

Finally, we need rest-of-state -- we need enhanced rental assistance up to 110 percent of fair market rent for people living with HIV outside of New York City. This already exists for every low-income

person living in New York City who has HIV. Why should people living outside of New York City be treated differently and only be allowed a rent of $480 a month? Which I defy you to find anywhere in New York State.

Thank you.

CHAIRWOMAN KRUEGER: Thank you.

First Senator? Any Senator? No? Any 4? Of course.

ASSEMBLYWOMAN PAULIN: Assemblymember Jensen.

ASSEMBLYMAN JENSEN: Yeah. My apologies, Senators.

Getting back to -- we've heard a couple of things about Medicaid from this panel. You know, it's my understanding that 40 other states utilize, via CMS, income eligibility data that is based in the most recent payroll data, whereas New York State determines eligibility via tax filings. With I think April 1st being the start of a one-year process for individuals to resubmit after the expiration of some mandates, is there a belief that using this free service

via CMS would help to make our Medicaid system more efficient and effective by getting closer to the original intent of why the program was created?

MS. KASSEL: I'm not aware of that particular detail, although I am aware of a lot of the activity that the state is pursuing for the preparation for when Medicaid renewals will resume. They are doing a tremendous amount of work to look at other sources of data, including SNAP enrollment and other public assistance. I'm not familiar with the specific question that you're posing.

ASSEMBLYMAN JENSEN: Yeah, it's 40 other states utilize this. It's a free offering from CMS. They would cover the cost.

MR. HAMMOND: I have to admit I'm also not familiar with that, although I would say it does sound like the kind of management improvement that as a state with a Medicaid program of our scale, we should be absolutely up-to-date on a technological thing like

that. So --

ASSEMBLYMAN JENSEN: I mean, I'm going to pat myself on the back that I confounded Bill Hammond. So fair job.

Pivoting to you, Dr. Gelman, when we're talking about the oversight prerogatives of our local department of health, would you have interest in -- with the proper funding, whether through counties or from the state -- to oversee some of the oversight over things like the cannabis licenses for inspecting the sites, the cultivation sites, the commercial licensing that's going to be in place, like bakeries and things like that?

DR. GELMAN: Thank you for that question. Actually, it's a multiprong answer to that question.

The Office of Cannabis Management has been carved out from -- as a separate entity outside of the New York State Department of Health. So currently it doesn't fall under the auspice of the New York State Department of Health. As such, there is a tremendous

degree of overlap between the programs that we implement at the local health department level in terms of enforcement actions and in terms of just inspection of facilities.

Having high-risk food facilities, as you've mentioned, and having that crossover -- because a tremendous amount of edibles are actually not stand-alone manufacturing facilities, they're typically -- even if you go to other states such as Colorado, Washington, Oregon, they are batch-manufactured in existing facilities.

So we would be glad to actually have that discussion outside, seeing the time. But there's a tremendous issue with enforcement of cannabis altogether.

ASSEMBLYMAN JENSEN: Thank you.

DR. GELMAN: Thank you.

CHAIRWOMAN KRUEGER: I do have a question. Thank you.

First off, Doctor, thank you for that answer. I'm also very interested in helping figure that out, because we certainly do want

everyone inspected appropriately. And I thought about the DOH-OCM issue, but not the local DOH issue. So thank you for that.

ASSEMBLYMAN JENSEN: There's a great bill about that if you're interested.

CHAIRWOMAN KRUEGER: Talk about it.

But I want to ask you about the Governor's proposal to reduce FMAP monies to the counties specifically for mental health services. And I know I heard from the Association of Counties how mortified they were by this potential I guess $397 million loss of Medicaid or FMAP funds used for mental health services.

What do you think the impact will be on public health from your perspective?

DR. GELMAN: So clearly there is -- thank you for that question. Clearly there is an impact, and we would be glad to provide a more detailed response in writing. Just given the fact that we have about two minutes, I don't think there's sufficient time to cover that in the detail that really is necessary.

And we absolutely welcome the opportunity to discuss the cannabis situation and how it impacts our current work at the local health department level. So I think that's a two-prong response and sort of a stay tuned, we will be glad to provide a more detailed answer in writing from NYSACHO.

CHAIRWOMAN KRUEGER: I would appreciate that. I think everybody on the committee would. Thank you.

Mr. Hammond, you consistently write about that we spend too much money on Medicaid, all the time. So I'm curious -- and I have great respect for you, and you know that -- does the Empire Center go out and look in the counties and the communities that are crying out for more access to healthcare, and so do you actually see too much money being spent somewhere?

I mean, is it what I used to call, as an anthropology student, you know, actual observational evaluation, versus you look at some numbers on a piece of paper and you say it sounds like it's too much?

MR. HAMMOND: Well, I mean, I think it's important to pay attention to numbers when you're talking about a program like Medicaid. I mean, that's -- I mean, I -- you're right, I don't go door to door and assess people's healthcare status.

I mean, I'll give an example of something where, according to the federal government, our per-capita hospital spending is the highest in the country and it's been rising the fastest in the country in the last five or six years. In 2015, we were 22 percent higher than the national average, and in 2020 we were 43 percent higher than the national average.

So somehow a lot of our money -- not just through Medicaid, of course, but a lot of our money is flowing into hospitals and it's not flowing to other things. Like we heard earlier about how primary care is underfunded. Part of the reason primary care is underfunded is because we put so much emphasis on institutional care.

Another area that I would say is

underfunded is public health, both at the county level and the state level. We were very ill-prepared for the pandemic, and part of the reason for that is that the Health Department has prioritized Medicaid over public health.

CHAIRWOMAN KRUEGER: No time; I can't ask you another question. The rules apply to me too. Thank you very much.

Other Senators? No, Assembly, sorry.

ASSEMBLYWOMAN PAULIN: That's all right.

CHAIRWOMAN KRUEGER: There's always another Assemblymember.

ASSEMBLYWOMAN PAULIN: Yeah, there's always another Assemblymember.

Assemblymember Nikki Lucas.

ASSEMBLYWOMAN LUCAS: Okay, hi. How's everybody doing?

This was actually something that was mentioned earlier, and I think, Mr. Hammond, you referenced it in your testimony as well. But the -- as it pertains to the federal carveout, it was mentioned that the State of

New York has yet to offer a financial plan to backfill the potential loss of the federal 340B revenues.

Would you happen to have any data that could break down the impacted loss, especially as it impacts Black and brown communities? This can really have an enormous impact in Black and brown districts like mine, which is the 60th, which is East New York, Brownsville, Canarsie, that really rely heavily on this type of funding.

MR. HAMMOND: So the information that I have about the financial impact of the carveout is based on what's in the financial plan. I don't have any independent source of information on that.

It unquestionably -- you know, it affects -- it affects providers that benefit from the 340B program, which at least in theory are serving high-need, low-income-type areas. So that's where the impact would be mostly felt.

ASSEMBLYWOMAN LUCAS: But no specific data.

MR. HAMMOND: I don't have that at my fingertips, no.

ASSEMBLYWOMAN LUCAS: Okay.

MR. HAMMOND: And again, I would be referring to what's in the financial plan.

ASSEMBLYWOMAN LUCAS: Thank you.

ASSEMBLYWOMAN PAULIN: Done?

CHAIRWOMAN KRUEGER: Oh, sorry.

Lea, ah. Senator Webb. Hello.

SENATOR WEBB: Hi. Thank you.

So my question -- well, first, thank you to all the panelists. Most certainly, Mr. King, thank you for sounding the alarm and raising even more awareness about the important challenges around 340B.

My question is for Lara. I was wondering if you could expound upon Access to Home. This is something that I've been doing advocacy for for quite some time, and I was hoping you could lift up specifically the program as relates to Access to Home for seniors and people with disabilities literally having physical access to their homes, and what that impact is.

MS. KASSEL: You know, I -- if memory serves, you are referring to a program that provides home modifications and other things that may not have to do with workforce or -- right.

So I'm not sure if there are any changes in this year's budget to that program. I'd be happy to check and --

SENATOR WEBB: Yeah, there's not. That's part of the problem. It's remained flat at $1 million for many years.

And you're talking about individuals who are seniors, people with disabilities, and having access to their home, and most certainly a good number of these folks are Medicaid-dependent. It is problematic. And so I was hoping you could lift that up along with your other proposals as relates to addressing health equity for those populations.

MS. KASSEL: Absolutely. I think, you know, programs like Access to Home go hand in hand with all of the other things that come to the fore specifically related to Medicaid,

such as Fair Pay for Home Care and wages, et cetera.

You can't -- in many cases you can't have one without the other, because if a person can't access their home, literally, or use the shower or the toilet, then they will not be able to continue to uphold their own right to live independently. So I firmly believe that all of it is part of that package.

SENATOR WEBB: Thank you.

MS. KASSEL: Sure.

CHAIRWOMAN KRUEGER: Thank you.

Assembly?

ASSEMBLYWOMAN PAULIN: I'm going to mix it up; I'm going to go in the middle, I guess with a question for CHCANYS and also for Medicaid Matters -- different questions.

For Medicaid Matters, I find it interesting, you know, the -- sitting next to each other there. I wonder if you've taken any position or believe that the Medicaid investments in the budget are adequate, and what might you do differently?

MS. KASSEL: That's a very good question.

ASSEMBLYWOMAN PAULIN: We have a minute, because then I have a CHCANYS question.

MS. KASSEL: Okay. I'll try to make it quick.

I mean, I think one of the things that we always bring to the table related to Medicaid and increasing rates or reimbursement or what have you, whatever is done needs to have some commensurate look, as I said earlier, about what are we doing on the institutional side but, more importantly, what are we doing for the providers that actually reach people where they are in the community.

And also, if we're increasing rates or reimbursement or what have you, let's make sure that it also shows quality, that the quality goes up. That access to services actually goes up. Because you can add money to the program, but if you don't go far enough to actually address the access issues,

you won't have actual changes.

ASSEMBLYWOMAN PAULIN: Thank you.

And lead. You know, we had that -- first thank you for the last three years of COVID. I mean, you were really front-line, you know, neighborhood health centers. And now the Health Department's proposing that you again front-line in trying to help resolve, you know, lead in children and so forth.

You know, on the Zoom we were on, you had suggested that the departments -- you know, 17 of them, I guess -- would need about $58 million to do the right kind of job. Which seems like a lot of money. It's a little more than 3 million per department. And I just wondered exactly what would be -- you know, what does that look like?

DR. GELMAN: Thank you very much for that question.

So NYSACHO actually has provided the breakdown in the written testimony, and it's actually on page 8 of 19 pages. And currently the New York State Department of

Health has designated 19 counties as --

ASSEMBLYWOMAN PAULIN: Nineteen what?

DR. GELMAN: Nineteen counties as having areas of high risk for lead. So zones within 19 counties.

ASSEMBLYWOMAN PAULIN: But two are within the Health Department, right, and 17 are local.

DR. GELMAN: Correct. So you're absolutely correct. Two are partial-service counties, and the remaining 17 are full-service counties, meaning that the county picks up the entire burden of having to correct those cases.

Now, when a local health department that's full-service goes out to actually have interventions -- and typically we receive the elevated blood lead level labs, and we follow up both with nursing and the clinical care for the chelation of that resident and that child, as well as an environmental health assessment determining what the underlying etiology is. So --

ASSEMBLYWOMAN PAULIN: Thank you.

Maybe you could just send me some information. Thank you so much.

DR. GELMAN: We'll provide the breakdown of what that actually entails. Because we've been dealing with lead for decades now on the local level. Thank you.

ASSEMBLYWOMAN PAULIN: Do you have anybody else? We have two 4.

CHAIRWOMAN KRUEGER: No, I don't see any other Senators raising their hand.

ASSEMBLYWOMAN PAULIN: Assemblymember Jessica González-Rojas.

ASSEMBLYWOMAN GONZÁLEZ-ROJAS: I really want to thank you all for your work. I think we've partnered in some way, shape or form over the last two years.

And Charles King, thank you for your advocacy. I really support it, and I think this Legislature is behind this.

My question is actually for Dr. Gelman. Regarding the tobacco ban on flavored products, does that include hookah?

DR. GELMAN: So the Governor's proposal is for menthol-flavored tobacco, so

cigarettes. And what the local impact is really what NYSACHO was advocating for as a public health measure, to extend the same and to apply the same rules, essentially, for any form of combustible, whether that's cannabis, whether that's anything else.

And where hookah comes into play is really on the local level, the health departments are tasked with enforcing the flavored vape ban. And it becomes extremely difficult to enforce that on the local level when the same rules for flavored vapes do not apply to other flavored forms of either combustibles or vapes, such as cannabis, especially open-cartridge cannabis.

So that's essentially kind of the crux of it, is the impact to public health and enticing -- with any flavored type of combustibles or vapes, enticing younger -- sort of illicit use by minors.

ASSEMBLYWOMAN GONZÁLEZ-ROJAS: I think the challenge I'm up against -- I in general would support this kind of ban, but I represent a district that has a large

Arab-American community, and we have a lot of hookah coffee shops -- it's a cultural practice. And I saw some language against that, but I know -- I know my community, and it's not an addiction, it's a cultural practice. And I'm really concerned about how it will impact a community that is already being policed and faces -- also through surveillance, to be further surveilled because of these cultural practices of smoking hookah.

DR. GELMAN: Thank you for that. And we would be able to discuss this in greater detail, because again, as I mentioned -- and we have about 50 seconds, but we would be glad to come to the table and discuss the public health impacts of that.

And as I mentioned, the enforcement is not civil. When local Health Departments go out to enforce, it's under Public Health Law, and the impact to retailers and to really sellers to minors especially. So we would love to discuss this in -- kind of as far as outreach efforts, education around any forms

of combustible or vape use.

ASSEMBLYWOMAN GONZÁLEZ-ROJAS: But as you understand it, the Governor's proposal right now does not include hookah? As written in her budget, correct?

DR. GELMAN: It does not. The current proposal is for menthol tobacco.

ASSEMBLYWOMAN GONZÁLEZ-ROJAS: Menthol tobacco, okay. Thank you very much.

DR. GELMAN: Thank you.

ASSEMBLYWOMAN PAULIN: Anna Kelles, Assemblymember.

ASSEMBLYWOMAN KELLES: Thank you, all of you, for being here.

I did want to just thank you, Mr. King, for bringing up the overdose prevention centers.

I do want to note that that is a hugely -- has a huge impact on the budget and Medicaid costs. Let me put my public health hat on for a second. The stigma around it literally drives me absolutely nuts, because the data shows that it increases treatment, people who seek treatment, decreases the

spread of HIV. It decreases the spread of hepatitis C, it decreases the spread of all particular types of diseases that we do not want spreading that cost the state a tremendous amount of money.

So just thank you, because it has been around since the 1970s in other countries, and our stigma is ridiculous.

Second, the only question I have for you, you were talking about the cost of housing for people with HIV living outside of New York City. Do we have an estimate of how many people that is and the differential in amount of funds that they would get for treatment -- for rent?

MR. KING: Yes. So we estimate that this would impact about 3500 households.

And the proposal is that localities would still pay their portion on the initial 480, which was legislated like 30 years ago, as the rental assistance number for people with HIV. People with HIV would pay 30 percent of any income they have above public assistance, and then OTDA would pick

up the difference up to 110 percent of the fair market rent. And this is in a bill introduced by Senator Hoylman and Assemblymember Bronson.

ASSEMBLYWOMAN KELLES: And just to be clear, it's 3500 households, so a very small impact on the state's cost. But it would be a huge impact on communities because being destabilized with housing, of course --

MR. KING: It is such little impact --

ASSEMBLYWOMAN KELLES: Correct.

MR. KING: -- that you would not have to add one dollar to the OTDA budget for OTDA to be able to absorb this cost.

ASSEMBLYWOMAN KELLES: Thank you so much.

And to Ms. Kassel -- that's how you pronounce it, correct?

MS. KASSEL: Mm-hmm.

ASSEMBLYWOMAN KELLES: You were talking a bit in your testimony about prioritizing the interest of consumers in Medicaid managed care. And I just want to give you a little bit more time to talk about

what you wrote in your testimony.

MS. KASSEL: Sure.

So we have for many years had a managed care workgroup that dives into these issues all the time. And we began this work when the original Medicaid Redesign Team prescribed that all of Medicaid be administered through managed care plans. That really ramped up our work in this regard because we thought that it would be important to really examine very carefully how people access their services when they are covered through a managed care plan. Is their access different, et cetera.

So some of the things that we're looking at for this year have to do with, again, going back to data and transparency -- we do have some legislative language that's been shared -- and looking more deeply at both consumer protections and managed long-term care, as well as deeper data collecting and reporting.

CHAIRWOMAN KRUEGER: Sorry, I have to cut you off. You're welcome to continue

offline afterwards.

All right, any other Assembly?

ASSEMBLYWOMAN PAULIN: No.

CHAIRWOMAN KRUEGER: Any other Senate?

Well, then we want to thank this panel very much for your participation today. Appreciate it.

And I am going to call up -- where am I? Hello -- LeadingAge New York; New York State Health Facilities Association; and Long Term Care Community Coalition. That's Panel E.

And for people following on the scorecard, Panel F might want to get ready to come up, which will be Agencies for Children's Therapy Services; The Children's Agenda; Consumer Directed Personal Assistance Association; and the Center for Independence of the Disabled.

Let's mix it up. Let's start to my right, your left. Hi.

MR. FOSTER: Hi. Can you hear me?

ASSEMBLYWOMAN PAULIN: Yes.

MR. FOSTER: Beautiful.

Thank you for inviting me to provide testimony today. My name is Stefan Foster. I am a policy researcher for the Long Term Care Community Coalition, and former volunteer ombudsman with the New York State Long Term Care Ombudsman Program.

The Long Term Care Community Coalition is a nonprofit, nonpartisan organization dedicated to improving care and quality of life for residents in nursing homes and assisted living. Roughly 117,000 people reside in nursing homes in New York State. Unfortunately, these vulnerable individuals are far too often subjected to substandard care, abuse and neglect. Care problems persist not because facilities lack resources, but rather because we fail to enforce the laws protecting residents and fail to hold accountable a powerful provider industry funded almost entirely by New York's taxpayers.

We have long known that insufficient staffing is a widespread problem in New York State, which consistently ranks among the

worst in the U.S., according to federal data. As an ombudsman for several years, I saw firsthand how this harms residents. Without a minimum staffing standard, safe care in nursing homes is essentially voluntary.

The nursing home industry complains that it does not receive enough money to provide sufficient staffing for residents. However, the recent lawsuits by the New York Attorney General against several major nursing home operators indicate that rampant financial fraud and self-dealing are resulting in understaffing and avoidable resident harm. Too many nursing homes use related-party transactions to hide profits by funneling vital public funds away from resident care into companies that they themselves own -- all while claiming that they are underfunded.

In just one of the AG's lawsuits, a nursing home was alleged to have paid a related party over $15 million in fraudulent rent costs.

The implications are clear. We need

to take meaningful steps at every level -- from empowering families to improving enforcement to strengthening financial integrity -- to stop nursing home operators from putting profits before their residents. We must improve oversight and accountability for nursing home care in our state. One resident who experiences inhumane care is one too many. And sadly, I have observed many.

For residents to receive safe and quality care, we must fully implement the laws around sufficient staffing and financial accountability which the Legislature promulgated two years ago. Moving forward, we must stand up for residents and families, rather than bow to the pressure from New York's nursing home industry.

Thank you for your interest in the well-being of residents and their caregivers and for the opportunity to provide testimony.

CHAIRWOMAN KRUEGER: Thank you.

Hi.

MR. HANSE: Good afternoon. My name is Stephen Hanse, and I have the privilege of

serving as president and CEO of the New York State Health Facilities Association, the statewide organization representing over 450 skilled nursing and assisted living providers throughout New York.

It's been said that one of the fundamental roles of government is to provide care for those who are unable to care for themselves. Nowhere is this more critical than with New York's nursing home and assisted living residents who rely on Medicaid for their care.

However, as a result of the state's 15 years of disinvestment in long term care, New York unfortunately leads the nation with the largest shortfall between the amount Medicaid reimburses nursing homes and the actual cost of providing essential care.

Specifically, New York statewide average Medicaid reimbursement for around-the-clock nursing home care was $211 per resident per day. However, the statewide average cost of caring for a Medicaid resident in a skilled nursing facility is

$265 per resident per day. New York's $211 statewide average Medicaid reimbursement, when divided by the 24 hours of care that is provided, equals $8.79 per hour.

$8.79 per hour is well below New York's minimum age, and this nation-leading underfunding of Medicaid has direct correlations to our state's long-term-care staffing crisis, the continued operation and ability to upgrade skilled nursing and assisted living facilities, and -- as we heard earlier from the hospitals -- the overall operation of the healthcare continuum.

The 2023-'24 Executive Budget acknowledges the state's history of underfunding of Medicaid and proposes a 5 percent Medicaid increase for skilled nursing and assisted living providers. While NYSHFA and NYSCAL are grateful for the 5 percent increase, it falls well short of the 43 percent increase it would take for the state to make up for its 15 years of cuts to nursing homes.

However, we recognize that a 43 percent Medicaid rate increase, while desperately needed, is a difficult increase in one fiscal year. That is why NYSHFA/NYSCAL is working with our partners at 1199 SEIU and LeadingAge and other advocates in respectfully requesting a 20 percent Medicaid increase for nursing homes throughout New York. States throughout the nation are providing significant double-digit Medicaid increases to skilled nursing facilities.

Without a 20 percent Medicaid increase in the '23-'24 state budget, New York will continue to fail in its responsibility to providers, employees and, most importantly, the vulnerable women, men and children who rely on essential skilled nursing care.

Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Next?

MR. CLYNE: I'm Jim Clyne, the president and CEO of LeadingAge New York. We have extensive testimony because we represent

the full continuum of care in New York State, from nursing homes, home care, assisted living and managed long-term care.

I can't go -- get into my testimony without addressing the first testimony. The only thing that was correct in his testimony was that we are largely funded by the government. Other than that, it was fiction. The Long Term Care Coordinating Council is essentially a front group for trial lawyers. Go to their website. The chair of their board makes her living suing nursing homes. So obviously they have a negative view of the care being provided.

With that said, I'd like to deal with some actual facts. As Stephen said, the state has the worst Medicaid rate when you compare the cost of care with the Medicaid reimbursement. Fifteen years of unfunding. If you look at the charts on page 5 and 6 of my testimony, you'll see that we've also gotten no investments or nearly no investments from the Medicaid waiver programs or from the transition pools -- nothing like

what the percentage of Medicaid we are in the state.

Without this significant investment, you are not going to see new beds open up. There's 6,600 closed nursing home beds, closed as in not staffed. They're legally to be open, but we can't find the staff. That's 6,600 more than in 2019.

That's why you're seeing backups in hospitals. Hospital emergency rooms are being affected, not only because they don't have the staff they need, but they can't get people up into the rooms because they can't get people out of the rooms to the nursing homes. So the underinvestment in long-term care is now affecting the entire healthcare system.

A 20 percent increase would be half of what the nursing homes should be being paid if we had had a COLA for the previously 15 years. The ultimate solution is to rebase the system. That means move up to a year that is closer to what's actually going on as far as the costs of providing care and who is

providing the care.

By rebasing the system you get a more accurate reflection of the costs and which individual facilities were providing the care.

The other area I just wanted to touch on is the proposal in the Governor's budget for med techs that would allow CNAs to provide medications. It's something that goes on in the OPWDD system right now. It's something that could be done safely, and it would really take the burden off nurses from having to pass meds, and allow them to do the nursing skills that we desperately need in our facilities.

Be happy to take any questions.

CHAIRWOMAN WEINSTEIN: Thank you.

We go to Senator Rivera.

SENATOR RIVERA: Thank you.

Thank you for being here today.

So a couple of questions, Steve. So you've had -- the request that you folks are making as far as increases in the rates, what was the percentage that you talked about?

MR. HANSE: Right now, so New York, under the prior administration, as Jim mentioned --

SENATOR RIVERA: Since I only have 3 minutes, I'm going to try and get --

MR. HANSE: Okay. Twenty percent.

Because 15 years ago the COLA was eliminated by the prior administration. And if you take -- you run the numbers, it would actually be 43 percent, where we are now. If that COLA was in place, we wouldn't be where we are today.

SENATOR RIVERA: So you're saying -- so just to be clear, you're asking for 20, not 43.

MR. HANSE: Correct. We are asking for 20 percent.

SENATOR RIVERA: Gotcha. So I was just confused about the --

MR. HANSE: We recognize 43 in one fiscal year is a pretty tough lift.

SENATOR RIVERA: Right. I just wanted to make that -- make sure for the record I understood that correctly.

MR. HANSE: Correct.

SENATOR RIVERA: So -- and certainly 15 years of disinvestment, and we've talked about this many times, there's -- it's very hard to kind of keep up if you're consistently trying to -- if you don't have enough to have stability, you constantly have to be running behind.

Jim, you said at the beginning of your testimony -- I just want to make sure I also understand that. So you said there was a fiction. You were referring to the testimony of this gentleman before you?

MR. CLYNE: No, the Long Term Care Coordinating Council, which is the front group for trial lawyers. They're not patient advocates. Just so you know.

SENATOR RIVERA: Okay. And -- all right, just wanted to -- just wanted to get those two things on the record.

And bottom line, 20 percent is what you folks feel would be sufficient to be able address some of the -- at least some of the concerns subsequent --

MR. HANSE: At least in the present. When we look around other states, they're realizing it and they're doing 27, 28, going into 30 percent. As we heard earlier through testimony from multiple folks, New York leads the nation in underfunding nursing homes. It's just one of the things we lead the nation in, in shortfalls in healthcare.

So again, 20 percent, while it won't solve the problem, it will really help move us forward. You heard in terms of the continuum. We are not -- we are -- as Jim mentioned, over 6500 beds are not able to be staffed. We can't compete against Target paying $22 now, based on the Medicaid rate.

SENATOR RIVERA: And anything you want to comment on in the last 32 seconds?

MR. FOSTER: I would just add that any increases in the budget must come with accountability for ensuring good care and including appropriate staffing.

I have direct experience working with residents and families, not as a professional lobbyist. We need to keep track of where the

money goes in nursing homes, and this can be achieved by fully implementing the safe minimum staffing and minimum spending laws that were promulgated by the Legislature two years ago.

SENATOR RIVERA: Okay. Thank you.

Thank you, Madam Chair.

CHAIRWOMAN WEINSTEIN: Thank you.

We go to Assemblywoman Paulin.

ASSEMBLYWOMAN PAULIN: Thank you, Madam Chair. Welcome back, thank you.

So I wonder if -- you mentioned rebasing it. Do you have any specifics, you know, with a certain way of doing it? You know, there's lots of ways.

MR. CLYNE: Yeah, it's a complicated process, and it would be great if the department would set up a workgroup to work on it that everybody could have a chance -- right now the statute already states that the state should be rebasing periodically. Certainly 15 years is not periodically.

We're going to work on some language that would try to put some parameters around

rebasing. Most other states do it every five years in order to catch up the cost and also sort out where the money goes for the appropriate providers.

ASSEMBLYWOMAN PAULIN: Thank you.

And to your knowledge, do you -- have there been any nursing homes cited for lack of safe staffing?

MR. HANSE: Based on the 3.5 or the new laws that are in place? The Department of Health is still promulgating the regulations. We're waiting for the final regulations.

ASSEMBLYWOMAN PAULIN: That's it for me. Thank you.

MR. CLYNE: That's an interesting point. I just want to give you one other point. So the 40/70 law already requires the spending on resident-facing care and direct-care staff, so that's already the law. Ninety-plus percent of my members meet that statute, yet 57 percent of them cannot get to the 3.5 hours.

And it's because the rate is too low.

So even when we're doing 70/40 like you requested, again, 90 percent of my members, they can't hit the 3.5 hour mark because there's just not enough money. Medicaid pays for 70 percent of the care.

ASSEMBLYWOMAN PAULIN: I would just ask one more question as a follow-up.

The 20 percent increase in Medicaid, would that open the 6,000 beds that we're talking about?

MR. CLYNE: That would open beds.

MR. HANSE: Absolutely. Absolutely.

MR. CLYNE: That's why we -- again, the 5 percent, it's a start, but it is not going to have an impact on the level -- I mean, there are waiting lists, I have a member in Westchester, 65 calls a day looking for placements.

ASSEMBLYWOMAN PAULIN: We did hear today that the money for safe staffing is supposed to still go out the door, so that was good news.

MR. CLYNE: If they actually do it. Now, just -- again, remember, trust but

verify, or something like that.

The money that you appropriated in '21-'22 never went out.

MR. HANSE: That's correct.

MR. CLYNE: So the money now, they're going to say it's going to go out, and in the last 30 days --

ASSEMBLYWOMAN PAULIN: So are you really saying the 5 percent is less than that?

MR. CLYNE: It's 2 percent. If the 187 goes out, then it's not a 5 percent increase, it's a 2 percent increase.

ASSEMBLYWOMAN PAULIN: Right. Thank you.

MR. HANSE: Just for nursing homes. It's just to expand -- there's 614 skilled nursing facilities in the State of New York. When the data is run, 75 percent of those cannot meet the 3.5 staffing requirement.

MR. FOSTER: I would like to add that roughly one-quarter of the facilities in New York State do meet the federally recommended 4.1 HPRD requirement. So safe

care is possible, but with sufficient staffing and it needs accountability. Otherwise it's essentially voluntary.

CHAIRWOMAN WEINSTEIN: Thank you.

We go to Assemblyman Jensen.

ASSEMBLYMAN JENSEN: Thank you very much, Madam Chair.

For Stephen and Jim, many of our long-term care providers are still being tasked with mandatory HERDS reporting on a daily basis. My understanding from working in a nursing home before getting elected to office is that this has tremendous administrative burden. What is the impact that this now-outdated mandate has on the ability of your nursing staff to actually administer care to their residents?

MR. HANSE: Sure.

To the best of my knowledge, New York is the only state requiring daily data reporting such that -- other states have gone to weekly, biweekly, monthly. What it is doing is taking skilled nurses away from providing direct care and basically making

them report data which actually is very voluminous. It's a daily, 365 days a year -- it takes a lot of time. So it's actually taking away from direct care on the floor.

ASSEMBLYMAN JENSEN: Last -- two years ago, and then we amended it last year, we created a Reimagining Long-Term-Care Task Force. That entity was supposed to -- the effective date was the beginning of December. Are either of you aware of either the cochairs -- I wish I would have had a chance to ask the commissioner earlier, whether it's the commissioner of Health or the director of Office for the Aging -- an understanding of when that task force may begin its statutory work?

MR. HANSE: I'm a member, I was appointed a member of that. I've gone through the background check. I have not received any information as to when the first meeting will be.

ASSEMBLYMAN JENSEN: Do you think that in listening to the statutory stakeholders that are supposed to be a part of that

task force, it's important for it to begin its work, to begin providing recommendations to the Legislature and the Governor on the ways to move our long-term care ecosystem forward into the 21st century?

MR. HANSE: I would say absolutely. As Jim mentioned, from rebasing to staffing, the whole spectrum of issues facing long-term care in New York need to be dealt with in a holistic way and not a siloed way. And I think that committee is the vehicle to do that. So I think that it is appropriate to move forward on that as soon as possible.

MR. CLYNE: And the Governor also has the Master Plan on Aging going on, but they are not looking at the long-term-care system specifically. So unless there's going to be -- unless this other group is going to look at it, then nobody's going to be.

ASSEMBLYMAN JENSEN: And I'm anticipating some more questions on the Medicaid reimbursement rate increase. But I do want to point out that I think it was last week the progressive bastion that is the

South Dakota State House of Representatives did pass legislation mandating that their state would have a hundred percent nursing home reimbursement -- and that it would still not cover the cost of care in that state.

So certainly while other states are choosing to make that investment, certainly we should take the time in New York State to fix the failings of a generation and ensure that we can actually have the costs of care covered for some of our most vulnerable residents.

MR. CLYNE: Yes. In the middle of COVID, remember, we took a 1.5 percent cut. But every other state was investing.

ASSEMBLYMAN JENSEN: Thank you both.

CHAIRWOMAN WEINSTEIN: Thank you.

We go to Assemblyman Gandolfo.

ASSEMBLYMAN GANDOLFO: Thank you, Madam Chair.

Thank you all for being here and providing your testimony.

So we heard a lot about staffing issues at our nursing homes and long-term

care facilities. If med techs were introduced in nursing homes, what kind of impact would that have on care and staffing in these facilities?

MR. CLYNE: I think it would not impact care at all. Again, in the OPWDD system, it's been going on for 50 years.

You certainly have to train the CNAs, and they have to work under the supervision of a nurse. But what it does is it takes an easier task of passing medications away from the nurse and allows the nurse to spend more time on things like assessment that only a nurse can do.

MR. HANSE: Yeah, I would actually say, to build upon Jim's point, it would improve care, because the nurses will be acting to the full extent of their license in providing direct care. As opposed to pushing a med cart.

ASSEMBLYMAN GANDOLFO: Great. That's it for me. Thank you very much.

CHAIRWOMAN WEINSTEIN: We go to Assemblywoman Jen Lunsford.

ASSEMBLYWOMAN LUNSFORD: Thank you.

This question is I guess for Stephen and Jim.

When we look at the 5 percent, there are many ways that that's reduced, whether it's the 187,000 for dealing with our county-run nursing homes, the 340B issues, the eFMAP issues will further reduce that. I wanted to give you an opportunity to discuss the difference in the solvency and quality of care in our nursing homes if they receive the 5 percent versus the 20 percent Medicaid increase.

MR. CLYNE: I think the 5 percent will certainly provide some stability. I still think there would be some closures of not-for-profit homes. We've had 50 homes close or be sold. So we're rapidly moving to a system without not-for-profit care.

But certainly the staffing, you would have a better chance of making the 3.5 hour requirement with that 5 percent. I'm not convinced the 5 percent would actually get us there. And again, I think there's some

confusion -- again, Medicaid is the overall payer. Medicare is the next biggest payer. The government totally controls what we get. There is no place to cost-shift, there is no place to get money from somewhere else. There's no ability to shut down your services. It's 24/7 taking care of people. So the only thing we can go back on is taking beds offline.

MR. HANSE: And one thing we've seen in New York City and we're seeing this in nursing homes now, many of the hospitals sign a contract with their nurses for a 19.1 increase. We have lost key nurses to the hospitals. And we don't blame them. They are making -- one of my members yesterday was telling me he lost his two top key nurses: One left for a hospital to make 25,000 extra dollars, and one 40,000. He couldn't pay.

ASSEMBLYWOMAN LUNSFORD: So we are certainly talking about now just a matter of increased care, but at 20 percent we could bring beds back online.

MR. HANSE: Yeah.

ASSEMBLYWOMAN LUNSFORD: And at 5 percent we are still going to continue to lose beds off the 6600 we currently lost.

MR. CLYNE: Because the first priority is going to be hit, the 3.5 staffing hour requirement.

ASSEMBLYWOMAN LUNSFORD: Thank you very much. That's all I have.

CHAIRWOMAN WEINSTEIN: Assemblywoman Buttenschon.

ASSEMBLYWOMAN BUTTENSCHON: Thank you to all of you for the important testimony.

This question is for Stefan. I know that you talked quite a bit about accountability. If you could choose the three top priorities for accountability, what would they be?

MR. FOSTER: Thank you for that question.

I think the three top priorities for accountability are financial transparency, ensuring sufficient staffing, and where excess monies are spent, where profits are spent, which is in sync with financial

accountability. And ... yeah, I think, honestly, that's what I would emphasize.

ASSEMBLYWOMAN BUTTENSCHON: Thank you, Chair. My colleagues asked my other questions.

CHAIRWOMAN WEINSTEIN: Thank you.

So back to the Senate. We have no other 4.

CHAIRWOMAN KRUEGER: (Mic off.) No other Senators.

So I want to thank you very much for your participation today -- I want to thank you very much for your participation, on mic.

And now we're going to ask the next panel to come down and join us, and that will be the Agencies for Children's Therapy Services, some guy named Steve Sanders -- I'm sorry. Assemblymember Steve Sanders, sorry. He was my Assemblymember, to be fair. The Children's Agenda, Brigit Hurley; Consumer Directed Personal Assistance Association, Bryan O'Malley; and Center for Independence of the Disabled-CIDNY, Heidi Siegfried.

We are mixing it up; I'm going to

start with Steve Sanders, to my right, your left, and then we'll just go down.

MR. SANDERS: Good afternoon. It's a pleasure to be here again with all of you.

My name is Steven Sanders. I'm the executive director of Agencies for Children's Therapy Services. My association provides most of the Early Intervention services for the 70,000 families and their infant and toddler children across the state.

Interestingly enough, just a few hours ago, the State Comptroller issued what I would refer to as a rather scathing report of the state's oversight of the Early Intervention Program. What the Comptroller found was that over half of the children enrolled in the Early Intervention Program do not receive all of the services that they have been diagnosed and evaluated to receive -- over half do not get the services that they need.

Over a quarter have their services delayed beyond the state's statutory period of time the services are supposed to be

instituted after the evaluation is completed and the family serve plan is adopted. And thousands of children -- thousands -- don't receive services at all.

So the question is why. Why are we failing? And the answer, sadly, is very -- is very easy to understand. It's not complicated. The rates in the Early Intervention Program are lower today than they were in 2009, lower today than they were in 2009. This in spite of the fact of rising costs, inflation -- we all know about that. So what is the ramification of these rates that have remained stagnant and in fact are lower than they were 14 years ago?

Well, not surprisingly, according to the Department of Health -- these are their statistics, not mine -- over 1800 therapists have left the Early Intervention Program in the last four years. Sixty-five agencies have closed. The ratio of children to therapist is at an all-time high. The bottom line is that there simply is not the workforce any longer to provide all the

services to all the children who need them. And that is causing families an enormous amount of misery and difficulties.

Fortunately, there is -- there is some good news here. And the good news here is that there is new money, new money in the budget that comes from the Early Intervention Program, $40 million -- unallocated, unspent -- that ought to be reinvested back into the Early Intervention Program to support a rate increase this year.

CHAIRWOMAN KRUEGER: (Mic off; inaudible.)

MR. SANDERS: Thank you.

CHAIRWOMAN KRUEGER: Next?

MR. O'MALLEY: Hi, everyone. Thanks for the opportunity to talk to you today.

My name is Bryan O'Malley. I'm --

CHAIRWOMAN KRUEGER: Can you pull it a little closer to you?

MR. O'MALLEY: Sure. My name is Bryan O'Malley. I'm executive director of the Consumer Directed Personal Assistance Association of New York State. We're

fighting for a stronger CDPAP for the consumers who rely on it and the agencies who administer it.

You have my written remarks, many of which has already been covered in whole and in part by other witnesses today. While I'm happy to take questions on that, I want to use this opportunity to briefly talk about some of the competing levers pushing on our long-term-care system and how the state has been addressing them.

Namely, the laudable desire to increase eligibility through programs such as the Medicaid buy-in expansion and last year's Essential Plan expansion to cover long-term care, which are all too often running into a competing desire to minimize costs within the programs themselves. When you don't provide the benefits in healthcare, coverage itself is meaningless.

The enrollment for both Medicaid and CDPA is clearly laid out in law and regulation. The state determines Medicaid eligibility; Maximus determines eligibility

for CDPA or personal care; the plan or county determines the number of hours a person receives. Fiscal intermediaries, or FIs, administer services. However, for years now, despite not having a role in enrollment or eligibility, the FI is continually blamed for the increasing levels of service.

The fact is the state's aging rapidly, and many who are aging are poor. Research indicates the poor will have a much greater need for long-term supports and services, in large part due to the physical impact of poverty. Families are doing what they can to keep loved ones at home, something the Governor and DOH do clearly like. They included LTSS in the Essential Plan, as I said, and they're proposing to expand the Medicaid buy-in for working people with disabilities.

We agree the expanded eligibility is a good idea, but can't help but notice the mixed messaging implicit in expanding coverage combined with cuts. If the Governor wants to lower enrollment, she should engage

in that discussion with you all. We can then discuss the merits of providing these services. But instead, the budget cuts providers and, worse, the wages of workers -- all of whom are merely trying to ensure people have access to the services the government has said it wants them to have.

Returning home care to minimum wage just throws gasoline on a workforce crisis that's already out of control. Making workers and CDPAs second-class home care workers by removing them from wage parity would devastate the only program holding the long-term-care system together. And the failure to require accountability to managed care plans to adequately pay for the services they're supposed to provide to their members, instead of stealing funds meant for agencies to pay workers and further empowering them to make deeper cuts, is just the definition of irresponsible.

Thank you, and I'm happy to take questions.

CHAIRWOMAN KRUEGER: Thank you.

Next?

MS. SIEGFRIED: Hi. Good afternoon. I'm Heidi Siegfried. I'm the health policy director at Center for Independence of the Disabled in New York, and our mission is to help people with all types of disabilities get the benefits and services and policies that they need to live independently in the community and not in facilities.

So that would be like the nursing facilities that were just at the last panel, and psychiatric facilities, prisons, people with disabilities are disproportionately in prisons and people need to live independently in the community. And that's their right under the Americans with Disabilities Act, and also under the Olmstead decision, which Assemblymember Simon mentioned earlier today.

And I do have a prop here. This is a very old bag that talks about the Olmstead Housing Subsidy. And that used to be the big thing that we needed to get people out of nursing facilities. This bag is so old it had a CC Tasic {ph} flyer in it.

Now the real issue is home care. Right? So here we just saw, even though the hospitals and nursing facilities wanted a 20 percent increase, they only got a 5 percent increase. We're seeing that the battle that we waged for home care last year has just been decimated, in the same budget. That facilities get an increase and home care gets a reneging on what we thought was a promise to always be, you know, $3 above minimum wage -- when it should 150 percent.

But the other issue that I wanted to bring up that hasn't been discussed today is we have a coalition called the Restore Home Care Access Coalition. And this deals with the fact that when we finish spending our increased FMAP, which requires us not to implement the Medicaid redesign team cutbacks on eligibility for home care, we are going to see a lot of people who are not going to be eligible for home care, are going to go without, are going to fall, are going to be hospitalized or may have to admit themselves into nursing facilities.

And this is really important to try to get this repealed this year because it's not been implemented only because the federal government has said: You cannot implement it. And our previous governor, he tried to sneak into a federal omnibus bill the ability to implement it, and our congressional delegation came forward and said, No, we're taking that out.

And so it's really important that people be able to access home care by having the same eligibility that they have now, which is not just two or three needs for physical assistance with activities of daily living. People need lots of other types of care in order to stay independent in their homes.

CHAIRWOMAN KRUEGER: Thank you.

Next.

MS. HURLEY: Good afternoon. My name is Brigit Hurley. I'm with The Children's Agenda, which is the anchor organization for the Kids Can't Wait Campaign.

The Kids Can't Wait Campaign is a

statewide coalition of parents, healthcare providers, advocates and grandparents and community members who are deeply concerned about young children with developmental delays and disabilities.

And I come to you today with three messages that are reflected in my testimony that you all have. But I want to make them very clear.

Number one, there are too many children in New York State waiting too long for developmental services.

Number two, they are waiting because a history of inadequate reimbursement rates has caused a hemorrhage of providers from the field.

And number three is that you already have a partial solution to this crisis with the Covered Lives Amendment, as Steven mentioned.

New York State is routinely failing to comply with requirements of the federal IDEA legislation, and in doing so is losing the chance to intervene when brain development is

most adaptive. In a child's early years, more than one -- listen to this -- more than 1 million neural connections are made every second. So imagine the impact this has on an infant who needs services and needs to wait months.

Kids Can't Wait was in Albany a few weeks ago, and we met with some of you, I know. You might have met Lynn. Lynn has a 2-year-old son named Timothy who has been waiting for speech therapy services for over a year. So half of his life he's been waiting for services that he was evaluated for and was determined appropriate for his development. So this delay is of course going to impact Timothy, but it is also going to affect New York State taxpayers likely in special education services needs for the rest of his school career.

So Timothy and his family are not alone. In '21-'22, 47 percent -- similar to what the Comptroller found, 47 percent of eligible infants and toddlers experienced delays in receiving therapies beyond a 30-day

deadline required under federal law. From 2017 to 2021, there was a 27 percent drop in the percentage of children receiving services on time.

In addition to delays, we're also concerned about the number of families that are now being limited to telehealth-only service delivery, regardless of whether or not that's best for the child.

For these reasons, The Children's Agenda is making the recommendations that are in my testimony --

(Laughter.)

MS. HURLEY: -- an 11 percent increase in reimbursement rates and enhancements for in-person delivery.

CHAIRWOMAN KRUEGER: Thank you all.

I know that Senator Rivera has questions.

SENATOR RIVERA: I do.

Thank you for being here, folks.

I want to ask Heidi in particular, there's one thing that we haven't heard about today, and it was brought up to me kind of

late in the whole process. But let's talk a little bit about the health home proposal that the Governor's putting forward. In particular, I want you to give me a sense of what your organization's position is on it, particularly as it relates to folks who are physically disabled.

MS. SIEGFRIED: I'm not that familiar with the health home proposal. I have seen that there's been difficulty with implementing the health home so far, so people haven't always gotten the services that they're supposed to get in these health homes. But --

SENATOR RIVERA: So I certainly would suggest that you do a little digging into it. I'm -- I have -- Bryan?

MS. SIEGFRIED: Yeah, I was just going to suggest Bryan.

MR. O'MALLEY: I have a vague awareness of it. I think that what we're seeing is what is often the case. The health homes are providing the care management that, frankly, MLTC was supposed to provide and

never has.

The health homes, for providing that care management and having successful results, are being punished, and the people who rely on them are being punished by pulling people who are succeeding because of this care management out of the health home and subjecting them into the MLTC sphere, where they will lose care management.

I think, you know, this is not an area we are explicitly focusing on, but I think the health home model is a much better model for New York to be looking at than the MLTC model.

SENATOR RIVERA: Okay. And, Heidi, earlier you -- I figured that you were talking about some of the changes that have yet to be implemented by the state as relates to activities of daily living -- activities of daily living.

MS. SIEGFRIED: Oh, yeah. Right, right.

SENATOR RIVERA: Right. So I wanted for you to talk a little bit about that,

since the state has yet to implement this. We just have a minute, but if you could talk about the consequences that you foresee if this new eligibility requirement goes into effect.

MS. SIEGFRIED: Well, I mean, it requires that you need physical assistance with three -- well, more than two activities of daily living, and if you have a diagnosis, which is completely -- you should not have a diagnosis-based eligibility. But if you have a diagnosis of Alzheimer's or dementia, that you could have less need.

But whenever we present examples of people to legislative staff and we say, do you think this person would be eligible, everybody always thinks that they are. And they aren't. And one of the biggest things is the housekeeping which is needed, which is what they call IADLs, instrumental activities of daily living. People who just needed that would be completely, you know, ineligible.

Now, we try not to scare people, so we want to let people know that they're going to

be grandfathered if they get it now. But for people who are coming forward in the future, they won't be eligible.

SENATOR RIVERA: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Assembly.

CHAIRWOMAN WEINSTEIN: Assemblywoman Paulin.

ASSEMBLYWOMAN PAULIN: Thank you.

So I'll give you a chance to talk about the 40 million, Steve.

MR. SANDERS: This is my chance?

ASSEMBLYWOMAN PAULIN: Yeah, you got your chance.

MR. SANDERS: Okay. It's a little bit complicated, but we don't have time to get into the complexities, so let me just say this as succinctly as I can.

For the first 25 years that the Early Intervention Program existed, the first payor was commercial insurance. If a family was covered by Prudential, MetLife, whatever, the services under the Early Intervention Program would be billed to commercial insurance.

What we found over the years, the state found, is that -- no surprise -- commercial insurance was very good at denying claims. Eighty-five percent of the Early Intervention claims that were submitted to commercial insurance, they rejected. They paid about $12 million -- out of a $700 million Early Intervention Program, each year they paid $12 million.

So finally the Legislature a year ago decided -- Assemblywoman Paulin was the sponsor of the bill in the Assembly -- decided that let's not -- let's not bill commercial insurance anymore, they're not paying. We're not going to bill them anymore, but we're going to assess them an amount of money that we believe is their fair share. And that amount of money is $40 million.

So commercial insurance is assessed $40 million a year. They used to pay 12. The difference between 40 million and 12 is 28 million. You see, whatever commercial insurance used to pay -- $12 million -- would

now be paid by the state and the counties, 50/50. The state would pay 6 million more, because commercial's not paying for it, and the counties would pay 6 million more because commercial insurance is not paying for it.

That leaves $28 million from the assessment, commercial insurance's fair share, that ought to be reinvested back to where it came from, the Early Intervention Program. That $28 million is unallocated, it has never been in the budget before, it is unspent. There is no reason in the world -- rationally, politically, economically -- why that money ought not stay in the Early Intervention Program to help underwrite what Brigit Hurley said is the request, which is an 11 percent rate increase.

ASSEMBLYWOMAN PAULIN: And I would argue that was the purpose of the legislation.

I have one question for Bryan. So -- thank you.

CDPAP. How many workers would be affected by the wage parity loss?

MR. O'MALLEY: That's a great question that we would know the answer to if Assemblymember Gonzalez-Rojas' data transparency bill were passed.

(Laughter.)

MR. O'MALLEY: But right now that sits in DOH and I have never FOILed it.

ASSEMBLYWOMAN PAULIN: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Senator Brouk.

SENATOR BROUK: Thank you all. Thank you for being here today. A special shout-out to my Children's Agenda organization over there holding it down in Rochester. But obviously you all do so much work statewide. I'm proud to house the organization that's housing Kids Can't Wait.

And so I do want to ask this question, and then -- you know, Brigit, I would love for you to kick it off, and if we've got more time I would love to hear even more.

But, you know, for me one of the things that always sticks in my head when we're talking about the Early Intervention is

exactly what Brigit said -- and I want to make sure I get this right -- one million neural connections per second. And I think that's important because when we talk about children developing, especially infants and toddlers, we can't operate in months or years, we're operating in literal seconds and days.

And, you know, one of the things that's frustrating to me is that we seem to never be able to get this done, year after year, to get these rates up. And I don't think people are fully understanding when you don't have an Early Intervention like this for young people, what happens five years, 10 years, 15 years, 35 years when they're out in the workforce, going to school or what have you.

And so I just want to put, you know -- I want to emphasize that, that we are talking about these crucial, crucial times in these children's lives that we are completely failing them. And we don't get a redo. And so I would love for you to -- and now I've

taken half the time. But I would love for you to illustrate what it does look like down the road when we are failing these children and unable to bring them these services.

MS. HURLEY: So two things come to mind, two stories. One is a child who had made some progress pre-pandemic and then regressed because services were not available during the pandemic, and he stopped saying "I love you" to his mother.

Second is a young family who had a -- brought a child, an infant, a premature infant home from the NICU and normally, you know, years ago they would have gotten a visit that day from Early Intervention to help them manage their baby's feeding tube, and they waited two weeks for that visit. That's what I would say happens.

SENATOR BROUK: Thank you.

MR. SANDERS: Let me just -- with three seconds, let me just add one more point. The Comptroller's report, which pretty much outlined the consequences of underfunding the Early Intervention

Program -- services delayed, services denied -- is particularly more acute in minority communities. That's what the Comptroller said.

If you are Black or you are Hispanic, those numbers rise dramatically. You are much less likely to get services or services on time. So -- so there it is.

CHAIRWOMAN KRUEGER: Okay. Assembly.

CHAIRWOMAN WEINSTEIN: So we go to Assemblyman Jensen.

ASSEMBLYMAN JENSEN: Thank you very much. Thank you very much, Madam Chair.

I was very happy a few months ago to stand beside The Children's Agenda in support of increasing Early Intervention services, and shared my own personal story with Early Intervention and the journey my son's currently embarking on.

So we're talking about adding funding to provide greater capacity for children to receive services. But could you talk a little bit more about increasing the capacity of actually the service providers, and

ensuring that if we're able to grow the amount of children eligible, that we actually have the people to provide those services.

MS. HURLEY: Right. So that's the -- that is the key. You know, we're a child advocacy organization. I'm not used to talking about service providers getting increases; I'm not an advocate for providers. But that is the key to this, to getting kids and families services, is that.

And the people who are currently providing services are basically, you know, missionaries. They really don't break even providing the services -- partly because they don't get reimbursed for anything beyond just the actual reimbursement rate. So they may travel, you know, an hour to get to a family and provide a service, and they get paid as much as somebody who drives down the street to provide a service.

So that's one of the reasons why we are concerned about this telehealth growth. Not because telehealth is a bad thing -- telehealth is an amazing thing, and it's

going to be part of our lives moving forward. But when a child -- I mean, you can imagine a six-month-old who needs physical therapy; telehealth is probably not the best way to deliver that service.

So that's why we're looking for enhancements, so that if you do deliver services in person, you will get reimbursed for travel or for mileage. You know, we're not in the business of deciding what those enhancements are. We're leaving it up to the Department of Health.

But all of those -- if you talk to the -- we brought 12 students from Nazareth College here when we came, and all of them were here to say "I have no incentive to go into Early Intervention" -- because they get paid so much more in other settings.

MR. SANDERS: I'd just like to underscore the point again that since 2019, over 1800 rendering providers, therapists, have left the Early Intervention Program. Sixty-five agencies have closed. And the reason for that is their costs have exceeded

reimbursements. It's very simple economics.

And it's worse still in minority communities.

ASSEMBLYMAN JENSEN: Yeah, and I shared the story of my own son. You know, he's four now, he's in full-day pre-K, so he gets services through pre-K through a local provider. But when he was in daycare, the only reason he was actually eligible for services was because there was another child in his daycare class that was there the same days that he was, and they were both eligible for group treatment.

So if my son would have been going on a different day or he would have needed individualized service, then he would have not had an available provider. So we certainly have to close that gap.

CHAIRWOMAN KRUEGER: Thank you.

Any other Senators? You're not a Senator, but I want to get everybody's attention --

(Laughter.)

CHAIRWOMAN KRUEGER: Well, you just

raised your hand when I said any other Senators, so I was double-checking myself. It's been a long day.

Okay, no other Senators, but at least one other Assemblywoman.

CHAIRWOMAN WEINSTEIN: We have several.

CHAIRWOMAN KRUEGER: Okay, fine.

CHAIRWOMAN WEINSTEIN: Several 4. We'll start with Assemblywoman Lunsford.

ASSEMBLYWOMAN LUNSFORD: Thank you very much. And thank you to my colleagues, who have done a great job helping illustrate why that 11 percent increase is so important this year.

I did want to give you, Brigit -- because I'm a homer from Rochester -- an opportunity to talk a little bit about the need for rate add-ons or higher rates when you're dealing with in-person services.

MS. HURLEY: Right. So this is something that we're seeing, honestly, growing rapidly in the New York City area, and then to a slower extent in other regions

of the state where providers are choosing to deliver services only via telehealth. And no big surprise there, right? They can see many more -- as I said, you know, you get paid per visit. And so if you can do six visits a day instead of three, you're probably going to prefer to do that.

The problem is that when you -- we're talking about infants and toddlers. Early Intervention provides services to children from birth through age 2. And I think we'd be hard-pressed to say that there would be a really great reason to provide telehealth service delivery to an 18-month-old.

And so we're simply saying, as is true in many other services, you know, just get reimbursed for the additional expenses -- again, like mileage or even time just to do your notes.

So there's a whole lot of work -- there's no -- there's now no longer any reimbursement for providers to -- say there's three service providers for one child. They no longer get reimbursed for the time they

spend talking to each other about the child. They don't get reimbursed for the planning process for what services a child is to receive. So it just goes on and on.

I mean, this is why I say the providers are real heroes, because they are not reimbursed for many of the things that they already do.

ASSEMBLYWOMAN LUNSFORD: From our providers, what we're hearing is that they're not reimbursed for anything that is not the direct visit.

MS. HURLEY: Yes, that's true.

ASSEMBLYWOMAN LUNSFORD: And if we're going to incentivize our providers to do this work, incentivizing them for the recordkeeping and the travel that they have to do to provide these services seems pretty essential.

I also wanted to ask you a little bit about what happens to our kids who are more profoundly disabled. When they exit Early Intervention services and go into a school setting and the schools can't adequately

provide for those services, what are you seeing from your perspective of where those children are receiving their services from?

MS. HURLEY: So you look like you have a answer that you want me to say there, Jen. I don't know what it is, so I'll just -- unless you want to go ahead.

ASSEMBLYWOMAN LUNSFORD: No, go ahead.

MS. HURLEY: Okay. It's just that it's not -- so of course what happens is when those kids go into preschool special education, then they are that much farther beyond. When they enter the school system if they haven't gotten either, or inadequate treatment, then they're that much farther beyond. And if the school district can't meet their needs, then they are placed in 4410 schools, which is beyond the purview of this committee because it's -- they're governed by the Department of Education. But they --

ASSEMBLYWOMAN LUNSFORD: And we're seeing a decrease when kids are getting their Early Intervention services, between those

that enter the 4410s and the 853s than when they don't receive those services.

MS. HURLEY: Right, absolutely.

ASSEMBLYWOMAN LUNSFORD: Thank you very much.

CHAIRWOMAN WEINSTEIN: Any others?

CHAIRWOMAN KRUEGER: I don't believe I have any other Senators, unless somebody wants to join the Senate quickly. But you might have more --

CHAIRWOMAN WEINSTEIN: We have.

So next, Assemblywoman Kelles.

ASSEMBLYWOMAN KELLES: Yes, we could do this for many hours. I'm just trying to get everything in at three minutes.

So quick questions about the direct -- the DPAs and home healthcare aides first. Do we have an estimate of the comparable cost of actually officially sufficiently supporting DPAs and home healthcare aides compared to what the impact would be of how many people are going to nursing homes? The cost of nursing home care versus home healthcare.

MR. O'MALLEY: The cost of home

healthcare is substantially cheaper by tens of thousands of dollars per year.

ASSEMBLYWOMAN KELLES: So tens of thousands of dollars per person. Do we have a sense of what the current demand is of how many people need home healthcare aides right now that don't have them because they don't exist because the pay is so low?

MR. O'MALLEY: I unfortunately don't have that number off the top of my head.

What I can say is that we have been measuring that via surveys in CDPA for the past seven years. And last year when we released our last version of the report, those numbers were higher than they have ever been before, and continuing to grow.

ASSEMBLYWOMAN KELLES: In the thousands.

MR. O'MALLEY: Yes.

ASSEMBLYWOMAN KELLES: Okay. And just moving to childcare -- thank you, I appreciate that. Actually, one other question. Eligibility requirements. My understanding is they're going from cognitive

and physical and you need at least one, and there's about 22 different things that can qualify you, and it's going down to about seven and you have to have at least three of them, and it's only physical, no longer cognitive. Is that correct?

MS. SIEGFRIED: Well, I mean, the fact that the Alzheimer's diagnosis or the dementia would -- you know, that's cognitive. So, you know, it's factored in.

But yes, there's a huge long list of different things that you -- that would make you eligible for home care and --

ASSEMBLYWOMAN KELLES: So that's our way of saving money, by cutting eligibility.

Moving to childcare, really appreciated Early Intervention. I just wanted to make sure it's on record, I'm so appreciative of what you said, that it's the first three years are so important because there is, after those first three years, a tremendous decline in how many neural -- you know, the connections are made. Huge, precipitous decline.

So literally if we don't catch it in those first three years, we won't catch it. And those are very highly correlated with hearing language, cognitive development -- we set that stage for life.

So thank you for bringing that up, and just a few questions. One is, how long does it take for a provider to actually get paid, an Early Intervention provider?

MR. SANDERS: It used to take a very long time. It used to take sometimes four, five, six months.

With the elimination of commercial insurance as the payor, customarily I would say now it is somewhere between two to four to five weeks.

ASSEMBLYWOMAN KELLES: And that's a good thing. That's why we lost providers.

One last really quick question -- thank you so much.

MR. SANDERS: You're welcome.

ASSEMBLYWOMAN KELLES: The no add-ons in the budget, that's not in this budget and we haven't had it for years, correct?

CHAIRWOMAN KRUEGER: Excuse me. Time's up.

CHAIRWOMAN WEINSTEIN: The time's up. Can't ask a question with one second on the clock.

ASSEMBLYWOMAN KELLES: I'll follow up. Correct. The answer is yes.

(Laughter.)

CHAIRWOMAN WEINSTEIN: Assemblywoman Simon.

ASSEMBLYWOMAN SIMON: We're very good at answering our own questions here.

(Laughter.)

ASSEMBLYWOMAN SIMON: So I have a question -- and I want to thank all of you for the work you're doing. This issue with the IE is huge, and the CDPAP is critically important, as you know. And it's so much of a more bang for our buck, and we're not using it. And it's pretty disgraceful.

I kind of want to just sort of piggyback on the EI issue -- or issues. And today a Washington Post article just came out on -- they've been scanning brains from

prenatal to 100 about different connections and things, and apparently the thickness of the cerebral cortex peaks at two years old. So again -- and we know our prime language learning years are zero to three. Do you have any perspective -- you know, EI is under Department of Health. The Committee on Preschool Special Education, that becomes Department of Education.

Do you have any sense whether EI would be different if it was under NYSED versus Department of Health?

MR. SANDERS: Very difficult question to answer. As a matter of fact, going way, way, way, way back when I was sitting on your side of this table, I was involved in the creation of the New York State Early Intervention Program, and there was a debate should it go into the State Education Department, does it belong in the Department of Health -- because it's sort of a hybrid. It's education, it's health-related.

For whatever reason, the decision was made to make the Department of Health the

lead agency.

I think the answer to your question goes back to the very premise of our concern, which is money. And would -- would the Early Intervention Program be doing better in terms of its funding if it were under the auspices of the New York State Education Department? I don't know.

But what I can tell you is that under this Governor, two budgets in a row, zero. That followed her predecessor, who for 10 years provided virtually zero. And as I said at the outset, the rates are actually lower in 2023 than they were in 2009. What service, what business can survive with those kinds of metrics?

So I don't know the answer to your question. I'm not sure. But what I am sure about is that whether it's in the Department of Education or Health or Transportation or Agriculture, it all comes down to funding, which simply hasn't been there in recent years.

MS. HURLEY: Could I add something

just quickly to that? Which is just that the Early Intervention providers have not received any COVID-related bonuses or retention bonuses. So ...

ASSEMBLYWOMAN SIMON: Thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

To the Senate.

CHAIRWOMAN KRUEGER: See, I didn't think I had a question, but I do now. Because I went to go read that audit by the Comptroller's office, Steve's -- and the Senate -- sorry, the response by DOH to the audit is that the delay and lack of services is because parental consent is not available.

Have you ever heard that as a reason that we're so radically not providing services that we used to provide?

MR. SANDERS: No. No. No. I think it's important to understand the process. A child generally enters the Early Intervention Program with a referral from the pediatrician. So it's very often the pediatrician who discovers that there is a delay, a possible developmental disability.

The parent probably has noticed that the child is not reaching their milestones.

The parent wants services. The parent can't access services. So if what the Department of Health is saying is that because most of the children don't receive all the services that they have been evaluated to need -- that makes no sense whatsoever, because it's the parents who have initiated trying to get help for their kids.

And this is most profoundly impacted in minority communities. That's the other thing that the Comptroller's audit indicated, which is that the lack of services, the lack of timeliness is exacerbated if you are a community with Black and Hispanic residents.

CHAIRWOMAN KRUEGER: Thank you.

Assembly.

CHAIRWOMAN WEINSTEIN: We go to Assemblywoman González-Rojas.

ASSEMBLYWOMAN GONZÁLEZ-ROJAS: Thank you all.

Today is February 28th, and I realize 13 years ago to the day, and almost the exact

time, I broke my leg snowboarding. I thought I was Shaun White, it was a, you know, a year where the Olympics were happening. It was very inspiring. I didn't quite make it. I couldn't walk for five months. I broke my femur. It was a home health aide who helped feed me, ensure I was showered, ensured I could function while I was healing.

This fight for fair pay is profoundly important for people who are elderly, for people with disabilities, and that includes temporary disabilities. I now walk, I function, I'm here today because of the work of that aide.

So, Bryan, I want to give you a few more moments to underscore the importance of this fight, why this wage -- why the proposed increase in minimum wage, which is important, undercuts all the work we've done to increase wages for our home care workers. And just what the shortage means for the health of New Yorkers.

MR. O'MALLEY: I want to -- the proposed minimum wage increase is a net

positive all round. The problem is removing the indexing to the minimum wage that just last year, y'all and the Governor determined home care's not a minimum wage job. And that is where the problem lies.

The rising tide needs to lift all boats, and this rising tide is going to sink home care.

When people can't get the services they need, they go to hospitals, they go to nursing homes. My board president wound up sleeping in her chair and going days without food because she couldn't find a home care worker to come feed her. She couldn't find a home care worker to transfer her to her bed. These are the real-life consequences of the home care shortage.

And we can talk about the fact that there are hundreds of thousands of home care workers that have been hired, but that isn't meeting the need of this rapidly aging state. Mercer Consulting -- not a bastion of liberalism -- has said we are not getting enough home care workers to meet the need,

and we have the worst workforce crisis in the country. That's driving up our healthcare costs, and it's worsening shortages in hospitals and nursing homes who can't discharge to the community because the home care doesn't exist.

ASSEMBLYWOMAN GONZÁLEZ-ROJAS: And what's the ask? What's the solution? I just want you to put it on record so we can remind --

MR. O'MALLEY: The solution is fair pay for home care. The solution is to stop attacking CDPA. The solution is to not do the Governor's wage parity cuts. And the solution is to let FIs operate the way they need to.

ASSEMBLYWOMAN GONZÁLEZ-ROJAS: Thank you.

CHAIRWOMAN WEINSTEIN: Assemblywoman Jackson.

(Pause; off the record.)

CHAIRWOMAN WEINSTEIN: Nikki, you're -- I don't know if we acknowledged you being here before. Assemblywoman Lucas.

Yeah, I think you're going to be the last one, then.

ASSEMBLYWOMAN LUCAS: I've been called a number of things, but never Jackson.

(Laughter.)

ASSEMBLYWOMAN LUCAS: But thank you, Madam Chair. I appreciate it.

So first, Mr. Sanders, I'd like to thank you for acknowledging the disparities within Black and brown communities. Because when things happen other places, it happens ten times, a hundred times more in our communities.

I do want to also highlight something that the Senator said. We've talked about a number of different services for different concerns, but there is an issue, however, with some parents not wanting to acknowledge some needs for their children in our communities. And just as a parent of a high school student, and have gone through schools and being very involved, that is an issue and it definitely needs to be addressed.

But what I'd like to know is -- are

two things. One, when it comes to home care workers, what is the ethnicity of most of these workers?

MS. SIEGFRIED: Well, I mean, the population is largely people of color and also immigrants, and even undocumented immigrants, we've found. I don't know how they get that number, but I've seen people report that they're largely immigrant and people of color.

ASSEMBLYWOMAN LUCAS: I kind of asked the question because I knew the answer, because I wanted it on record that this usually just happens to us. And it's a problem that really needs to be addressed, it needs to stop. And America just needs to be ashamed of itself for the treatment of Black and brown and immigrants because, again, it's just not fair.

Second, is there any data that supports the connection between the lack of services that are received and issues when it comes to homelessness, when it comes to crime? Because I live in the 60th. I

represent the 60th Assembly District. We are high when it comes to violence, we're high when it comes to issues of homelessness. When we look at the courts, like the surrogate's courts, it's very difficult to get representation for those folks that are having challenges because they can't afford to get the services.

So I'd just like you to also take a look -- you probably won't be able to respond -- but include these ideas in what you're looking at when you're representing and speaking about this issue. Thank you.

CHAIRWOMAN KRUEGER: (Mic off.) -- with that one now, but if you would like to answer it offline, you're welcome to.

And with that, we're done with 4 and Senators with questions. So thank you all for testifying here before us today.

MS. SIEGFRIED: Thank you.

MR. SANDERS: Thank you.

MR. O'MALLEY: Thank you.

MS. HURLEY: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

And I am going to call up Panel G: Medical Society of the State of New York; Pharmacists Society of the State of New York; New York State Nurses Association; CWA, Communication Workers of America; and 1199 SEIU.

And we're going to invite Panel H to get closer to the front, because we'll be calling them after. And that will be American Cancer Society, Planned Parenthood Empire State Acts, Hospice and Palliative Care Association of New York State, and the National Hookah Community Association.

Okay. So let's start at my right, and we'll go down to the left. Hi. You are? See if the light lights.

MS. HAYES: Hi. Good afternoon. My name is Debby Hayes, and the upstate New York Area Director for the Communication Workers of America.

Thank you for giving me the opportunity to testify on the need to ensure sufficient funding to help stabilize New York's hospital and healthcare workforce.

I'm a registered nurse and have been for 44 years, and I've worked in the healthcare industry for almost 50 years.

CWA District 1 represents about 15,000 healthcare workers across New York State, with a heavy concentration in Western New York, particularly in two struggling systems right now, the Kaleida Healthcare System and the Catholic Health System. The most urgent crisis facing healthcare institutions and our members across the state is staffing. Unsafe staffing predates the COVID-19 pandemic by decades, but the pandemic brought us to the tipping point.

While much of the world is now moving on from the COVID-19 pandemic, and the public attention on supporting healthcare workers has subsided, our members and healthcare workers across New York State continue to carry a broken healthcare system on their backs every single day.

Crisis-level short staffing and deteriorating hospital working conditions at the expense of patient care add relentless

stress to an exhausted, burned-out and overworked workforce. And unfortunately, there is no end in sight.

The staffing emergency in our state requires both a short-term and long-term response. Last year we were pleased to see the state make a major investment in the healthcare workforce pipeline with programs like Nurses Across New York. However, there is much work to do. The state must continue robust investment and incentives to get folks to join the healthcare professions, while focusing on getting workforce development programs online and increasing capacity at educational institutions and in clinical placements.

In the short term, the state must focus on supporting healthcare employers to immediately improve job conditions and raise wages in order to recruit and retain the current workforce.

While there is certainly a shortage of healthcare workers, the biggest threat is the shortage of good healthcare jobs. A recent

study from the Center for Health Workforce Studies identified workers leaving for better-paying jobs, and burnout is the biggest driver of difficulties in retaining healthcare workers in hospitals.

Hospitals and other healthcare employers must address staffing and workforce -- okay. And I submitted testimony, so all of it will be there for folks to look at. Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Next?

MR. MATHEW: Hi. My name is Benny Mathew. I'm a director at large on the NYSNA board of directors and a member of NYSNA's Steering Committee at Montefiore Medical Center in the Bronx, where I work as a full-time registered nurse in the emergency department.

I want to thank the legislators for giving us an opportunity to address the concerns related to the health and Medicaid proposals in the Executive Budget. We are supportive of many of the proposals in the

budget to increase access to healthcare and funding for hospitals, nursing homes and other healthcare services.

We do have certain areas of concern, however, about some aspects of the budget which are laid out in more detail in our written testimony.

First, we join with our fellow unions and advocates in calling for big increases in funding for hospitals and nursing homes, many of which face serious financial pressures. We urge the Legislature to: Increase Medicaid reimbursement by at least 10 percent, with the higher increases targeted to safety net providers; rescind or delay the elimination of the 340B drug program to make sure that all safety net providers are made whole and that the federal government approves alternative funding sources; target the 1 billion in new Healthcare Transformation Capital Funding to make sure that the money goes to the true safety net providers; fix the Indigent Care Pool funding to shift more funding to true

safety net providers in the form of directed payments or increased reimbursement rates; end the Medicaid cap and allocate funding for healthcare based on the needs of New Yorkers and not artificial spending caps.

Second, we support the Executive's proposals to expand access to care, but believe that they do not go far enough. NYSNA supports universal health coverage for all New Yorkers, which will also address a lot of funding disparities in the current system.

In the absence of passage of the New York Health Act or another plan for universal single-payer coverage, we would urge the Legislature to take the following steps to expand access to care: Expand the Essential Plan to include all uninsured New Yorkers, regardless of their immigration status, using federal waiver authority and existing Essential Plan reserves.

Reject the elimination of "provider prevails" for Medicaid participants. Make hospitals reopen their closed psychiatric

cares units and restore 850 inpatient beds, but also increase reimbursement rates for equalized psychiatric care payments, especially for the safety net hospitals that provide the lion's share of beds statewide.

Implement measures to further crack down on insurance company practices that delay payments and patient access to services to maximize their profit.

CHAIRWOMAN KRUEGER: Thank you.

Hi.

DR. FERRARESE: Thank you. My name is Dr. Heather Ferrarese --

CHAIRWOMAN KRUEGER: Bring your mic a little closer to you, Doctor. Thank you.

DR. FERRARESE: Sorry. Thank you.

My name is Dr. Heather Ferrarese, and I currently serve as president of the Pharmacists Society of the State of New York, better known as PSSNY.

PSSNY members are united in support for many of the Executive Budget proposals' pharmacy-related provisions. You will find the details in our written testimony. I

would like to focus my remarks on the April 1st implementation of the Medicaid pharmacy carveout.

Like many PSSNY members, I am a second-generation pharmacy owner. My father opened Bartle's Pharmacy outside of Binghamton 60 years ago, and he and I have been providing healthcare side by side since I earned my doctorate 25 years ago.

Ever since former Governor Cuomo implemented the managed care system, pharmacies have been under constant financial pressure due to underwater reimbursement by the plans and PBMs. The state finally agreed to transition back to fee-for-service when it realized all of the money that PBMs and others have been siphoning off the system. But the Legislature's two-year delay in the implementation of fee-for-service has let these parasites continue to thrive.

Under state law, we are supposed to receive a $10.18 fee for dispensing prescriptions in the Medicaid program. However, we actually receive 50 cents on a

prescription that's dispensed. As a result, independent pharmacy is currently subsidizing the Medicaid program instead of receiving fair reimbursement for our services.

Pharmacy deserts are growing across the state. Pharmacies are closing, even large chains, because the system simply does not work. In my rural area, a large corporate chain was recently excluded from the Medicaid network, which caused thousands of Medicaid patients to lose their pharmacy access. Meanwhile, independent pharmacies across the state report layoffs, decreasing store hours, cutting back on employee benefits, and owners taking personal loans to stay afloat. Yet we have no capital fund, no rate increase, and without fee-for-service, we have no hope.

Recent legislation has been introduced and framed as a compromise. However, the bill does not solve the problem because it leaves PBMs in the space, and it cuts the pharmacy dispensing fee down to $8.50.

On the other hand, the Governor's

proposal will make the 340B entities whole by reinvesting nearly 400 million into those entities. Today you have heard them testify that carveout is a net zero; in other words, they will not lose money. Make no mistake about it, anything but the on-time implementation of NYRx is a continued ask of pharmacy to be reimbursed negatively for the filling of prescriptions.

PSSNY and its members are urging you to support the return to fee-for-service in the Medicaid program.

Thank you, and I look forward to your questions.

CHAIRWOMAN KRUEGER: Thank you.

Next?

DR. PIPIA: Yes, hi. Good afternoon. I'm Dr. Paul Pipia. I thank you for the opportunity to speak.

I'm the chair of the Department of Physical Medicine at Nassau University Medical Center, and I am president-elect of the New York State Medical Society.

The Governor's proposed budget

contains a number of measures we support to enhance physician-delivered care to our patients, but it also contains concerning items that will adversely affect inpatient care. Our testimony has been submitted.

We thank the Governor for proposing to continue a number of important programs: The MSSNY Committee for Physicians Health, which absolutely is an essential program to help address the growing problem of physician burnout; the Excess Medical Malpractice Insurance Program, which provides nearly 16,000 physicians with a supplemental layer of liability insurance coverage, which otherwise would be unaffordable in New York's excessive high-cost environment; proposals to help ensure access to care in underserved areas, including the Doctors Across New York medical student loan repayment program, and proposals to increase the reimbursement for care received by patients insured by Medicaid and the Essential Plan.

However, we oppose some of the proposed burdensome new prior-authorization

requirements on physicians writing prescriptions for their patients insured by the state's Medicaid program. Physicians and their staffs are already drowning in excess paperwork and phone calls and are taking time away from patient care.

We're also very concerned with the proposal to require the DOH approval for private physician practices who wish to merge with other practices, which will reduce patient choice of care setting and prevent innovative ways of expanding quality care and delivery.

However, most importantly, we strongly oppose Part W, which would fundamentally restructure New York's healthcare delivery system by significantly expanding the scope of healthcare services delivered by PAs, pharmacists and others. We are deeply concerned these proposals would adversely impact patient care by completely removing the important oversight and coordination that a physician provides, particularly as it relates to the ordering of diagnostic tests

and evaluation of effective services.

With regard to proposals to permit physician assistants to practice independently after 8,000 hours of care, my residency was 16,000 hours -- but merely accumulating hours did not make me a physician. I had to achieve milestones which were set and constantly modified by national certifying boards that oversee residency training programs. I also had to pass a certifying exam, and every 10 years must complete continuing certification to maintain my board status.

These standards are crucial to ensuring patients receive the best possible care, and should not be overlooked.

Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Next, Helen?

MS. SCHAUB: Thank you very much for allowing us to testify today. My name is Helen Schaub. I'm the interim political director at 1199 SEIU. We represent about 350,000 healthcare workers throughout New

York State, from home care workers, including consumer-directed workers, to workers in FQHCs, to nursing homes, to hospitals and pharmacies. So we represent the broad spectrum of workers affected by many of the policies that you've been discussing here today.

A lot of things have been touched on; we've been named in some other people's testimony, so I just wanted to make a few points.

One, certainly people have talked eloquently about the real workforce crisis facing the healthcare industry, why people are leaving, the trauma of the experience during COVID. Certainly for the long-term care sector, the money and having to compete with Target paying a couple of dollars more than a nursing home is able to pay CNAs or that healthcare workers are making. The competition with agencies and working alongside someone who's making three times what you're making and has less strenuous work to do because they're not being given

the full complement of responsibilities that a staff nurse might be given.

And fundamentally, many people are leaving just because they can't provide the kind of care that they know their patients and residents and clients deserve. When they're working short-staffed, they go home every day, our members go home every day feeling like they couldn't do their jobs. And they couldn't do the kind of -- they couldn't provide the kind of care that brought them to be a healthcare worker in the first place. And many people just can't do that anymore.

So it's a vicious cycle that has to be addressed by a number of interventions, including being able to raise wages, especially for the lowest-paid workers. We really have a fundamental structural problem, which is that Medicaid rates have not been raised for 15 years. And I don't think anybody here can imagine that the costs have not gone up and particularly gone up exponentially during that period of time.

What we're really hoping that the Legislature will be able to do in this budget is start to fundamentally address that structural problem. Because if we don't, the foundations are shaky, they're going to keep cracking, they're going to fall. We have to recognize that costs go up, payment has to go up. And it's the state as a payer, particularly in the long-term-care system but also in the safety nets, that has to take responsibility for actually paying for the services that the Medicaid beneficiaries need and deserve. Because they're not going to be able to access those services. Already they're not able to access all the services they need because the payer is not paying appropriately for those services.

We are asking you to make those kind of investments, to increase Medicaid rates 10 percent for hospitals, 20 percent for nursing homes, to invest in the safety net institutions. We also believe there are savings to be had through the Managed Long-Term-Care Program and other programs.

So opportunities to right-size some of the problems, structural problems in the system.

CHAIRWOMAN WEINSTEIN: Thank you.

Senate?

CHAIRWOMAN KRUEGER: Thank you.

Okay. Senator Rivera.

SENATOR RIVERA: Thank you.

Two things. To the Pharmacists Society. So I thank you for being here today; obviously you've been here during most of the conversation that we've had during the day. So a couple of things that I just want to kind of say off the top.

There is -- I have been pretty consistent on the fact that I care deeply about community pharmacies in particular. I know that there's -- if Roger's watching somewhere, Roger Paganelli, who's a dude who has been consistently in my ear about this, I actually care, even though there have been some things said that I don't, particularly because of the bill that I introduced.

Two things that I will say. Number one, I believe that there is a good

compromise to be had by having an 8.50 floor for a dispensing fee, as well as protections that are in the bill. What I would say, and I will this publicly, as I said it privately earlier to your president, I remain open. If there are things you think the bill needs to do differently to be able to better protect pharmacists, I want to be able to hear about that and I want to be able to implement it.

But we feel pretty strongly -- I certainly do -- that we can't allow the transition to happen because of the impact that it will have on all the providers that we talked about during the day.

But I just wanted to say it to you, and publicly again: I remain open. If there's things in the bill that's currently out there, 5136, that you think don't adequately protect folks, I believe that is a good compromise. It is not 50 cents. It is not 10.18. But 8.50 is a good floor to start from. So I just wanted to say that.

And second, for -- for folks -- Helen, you obviously ran out of time but I wanted to

give you a little bit of time to talk about -- there was a question that I posed to the folks in the Health Department and the Medicaid director earlier. There's a report, the MLTC report that I'm not sure -- I'm not sure if it's even in my email inbox. It might be in there. But there are real questions that I have, and I know that we've got to talk about this, like: Is this serving us well? Is this MLTC system serving us well in the State of New York?

MS. SCHAUB: We would say no. You know, the -- it was a little more than 10 years ago when there was a decision to move the entire population of folks who need personal care under managed long-term care. At the moment, at that time, the promise was, A, it's going to save money, they're going to manage utilization, and it's going to be a step on the pathway to people being enrolled in fully dual-eligible plans where the state could potentially capture some of the Medicare savings. Which is an important goal if it were to happen.

It did not happen. I think 10 years ago people started walking in this direction; we're now over here (gesturing). Utilization has exploded. The state has not only not saved money, but spent a lot more money. And there's only a 17 percent of the population enrolled in dually capitated plans.

So we're left with this partially capitated system. We're expending a tremendous amount of administration, almost -- the vast majority of the plans and all the largest plans are for-profit, so we're including a lot of profit, to deliver one service. And we think we could deliver that much more efficiently and effectively.

SENATOR RIVERA: Much more to discuss.

Thank you. Thank you, Madam Chair.

CHAIRWOMAN KRUEGER: Thank you.

Assembly.

CHAIRWOMAN WEINSTEIN: Assemblywoman Paulin.

ASSEMBLYWOMAN PAULIN: So just to continue on the same theme, what ideas do you have for the future? I know that there are

some that you're thinking about.

MS. SCHAUB: So we believe that if you moved to what some other states, including Washington, including Connecticut, have done, what's called a managed fee-for-service system -- so you would need to have a care management program. You could spend about the same amount of money you're currently spending now on care management. But you would be -- the state would be paying the providers directly.

The state would know how much the providers are getting paid, which it currently doesn't know. It would know which providers are providing the services, both on the LHCSA and the FI side. And you would eliminate this very large administrative structure to deliver one service. It's not really insurance, because the vast majority of the money being spent is to deliver just the home care service.

We think, you know, partial capitation, it was -- there was a vision, it did not get realized, and we ought to be

taking a fundamental look at how best to deliver the service. We think if you've made that switch, we have an analysis that shows the state could save about 1.5 to 3 billion dollars a year.

ASSEMBLYWOMAN PAULIN: Thank you.

And to NYSNA, what ideas do you have to address some of the issues regarding the workforce shortage? How do you get more nurses into the system?

MR. MATHEW: The workforce shortage is kind of manufactured. We have 170,000 nurses in New York State not working in New York State, but they are licensed to work in New York State.

The hospital administrators and the Legislature, ask yourselves why they are not working in New York State. What is preventing them from working? Because of the working conditions. We mentioned earlier we go home with guilt, we go home as co-conspirators in a crime. How long can you work like that? If you improve the conditions in hospitals, nursing homes, and

all other healthcare facilities, yes, we will work.

And having the compact nursing licensure, it's not an answer. We had it -- that for the last three years. Did it make any difference? No. Montefiore, we had less than 300 open positions three years ago, now we have over 700 positions. So the compact licensing, it doesn't work.

What works? Have a safe place for us to work.

ASSEMBLYWOMAN PAULIN: Thank you.

That's it for me.

CHAIRWOMAN KRUEGER: Thank you.

Senator Rhoads.

SENATOR RHOADS: Thank you, Madam Chairwoman.

Obviously the home healthcare -- home healthcare -- healthcare worker shortage is something that has been a crisis for some period of time. The question that I have -- and it's specifically for Ms. Hayes, because I know that you mentioned this topic first -- during the course of the pandemic, about

33,000 healthcare workers ended up either retiring or being let go as a result of the vaccine mandates. Our understanding is that the vaccine mandates are continuing in effect, despite the fact that as of May 2023 the Biden administration has declared an end to the pandemic.

Do you see this as being problematic, the fact that we have qualified healthcare workers who are out of work simply because they've refused to get a vaccine?

MS. HAYES: I believe that it's problematic in that we lost, in one of our health systems, 300 employees, 150 of which were nurses. I have my own personal opinion related to vaccinations, and to me it makes sense and it made sense that healthcare providers working at the bedside be vaccinated. But you can't deny the fact that it pushed healthcare workers out of the system.

SENATOR RHOADS: Thank you so much.

And Mr. Pipia -- Dr. Pipia, excuse me, could you -- when we're having physician

assistants, when we're having pharmacists that are actually pharmacists that are writing orders, for example, for prescription medications, when we have nurse practitioners, for example, that are authorizing tests, as has been proposed in some legislation that's before the State Legislature -- what problems does that create?

DR. PIPIA: Okay, so nothing stops any of these individuals to quit their profession and go to medical school, okay? They're also a very valuable -- and it's in my testimony, a very valuable, integral part of the test -- of the healthcare team. They provide essential services. So I'm not saying anything tremendously bad about them.

But at the end of the day, there should be somebody who's a physician that should be heading the healthcare team, and that's our position. We think that that person should be the physician. Just accumulating hours, as I said earlier, doesn't make somebody competent in their

field --

SENATOR RHOADS: Are you aware of any studies that -- I've read about the South Mississippi System's accountable care organization --

DR. PIPIA: Right, so there was a study that was done by the AMA -- I think it's referenced in our testimony -- that says that those people as physician assistants and possibly nurse care providers, order more tests than physicians do. And that's a study that was done by the AMA.

SENATOR RHOADS: Thank you.

CHAIRWOMAN WEINSTEIN: Assemblyman Ra.

ASSEMBLYMAN RA: Thank you.

Dr. Pipia, also about the kind of same topic with Part W. Do you have suggestions -- and I think you do, because I think we've spoken about this in the past -- but about other things that the state could be doing, as opposed to scope of practice changes for non-physicians, to help, you know, address shortages of people -- of doctors in certain specialties in parts of

the state?

DR. PIPIA: Right. So among the many things is New York -- and it's in our testimony, and there's charts -- with the highest malpractice costs in the country, okay. If you look at Texas, it might be like 2.46. In New York, it's like 24. So it's like, you know, 12 times what another big state pays.

So if that could be lowered down, if there were medical courts for that type of stuff, it would be good.

Also, the Doctors Across New York is a program that's funded. We probably could, you know, find another way to let other people know that that exists, and help make sure that that program gets more utilized.

And then also, you know, there's a lot of burdens in this state that are negative towards physicians, a lot of things -- I mean, Medicaid pays us much lower than the Medicare ceiling, and now you're going to have to make a call and task somebody to call up and get a pre-authorization on a

medication.

So New York is not the most friendly environment for physicians to work in, and people are leaving New York quite frequently.

ASSEMBLYMAN RA: Thank you.

And just for the Pharmacists Society, I know it's mentioned about the transparency piece, drug transparency piece in the budget, saying it should be removed from the budget process. And I think I would agree, because, you know, it's a complex matter and we want to get to the right result. But if you can elaborate on how that impacts your members, if something were to go forward that maybe doesn't fully treat each of the entities in that chain appropriately.

DR. FERRARESE: So the return to NYRx would have one preferred drug list, versus many separate drug lists for each Medicaid managed care plan. It would cover 100 percent of FDA-approved drugs. It would streamline the prior authorization process for these patients. It would return oversight to the Department of Health and

New York State, which would allow for transparency into these payments and remove PBMs from the mix.

ASSEMBLYMAN RA: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Senator John Liu.

SENATOR LIU: Thank you, Madam Chair.

I want to thank the panel for your patience today, and testifying.

I just have a question for Dr. Pipia, which actually Assemblymember Ra started talking -- asking you about it. I think one of your responses was New York State makes it too difficult to be a doctor, and therefore we don't have enough doctors?

DR. PIPIA: Let me clarify what I mean by that.

The standards are the same in every state. However, the amount of hoops and loops and hurdles that --

SENATOR LIU: And the paperwork.

DR. PIPIA: The paperwork and all of that kind of things, yes. I mean, like to get approval for something, I have to call

up -- and I'm the physician, and somebody else who's not a physician is making the decision.

SENATOR LIU: Oh, I understand. I understand it's a pain in the neck. Dr. Pipia, I tend to agree with you. You know? I mean, you go to medical school, you spend a huge amount of your life studying to become a physician, and physicians are highly skilled, highly qualified. And we don't want to take anything away from them. So I tend to agree with your statements and your written testimony.

But we are approached over and over and over again by nurse practitioners and other participants in the medical field about expanding their scope of practice. And one of the main reasons that they offer, which I have always found it hard to refute, is that they're just -- there are lots of communities where physicians are not available.

And, you know, you cite the difficulty or the hassle or paperwork of being a doctor in the State of New York. I don't think

there are any shortages of doctors in the New York metropolitan area. But there are parts of the state where it's much more difficult.

So in order to make sure that those fellow New Yorkers have adequate care, to the extent that physicians just are not available for whatever reason, don't we need to deliver the care in some other manner?

DR. PIPIA: Okay, so you're right when it comes to that. The thing is we're asking for a physician to be oversight on them.

In preparation for this testimony, we had -- I had a PA that worked for us when I was in Brooklyn at Downstate. And this was the best PA I ever saw in my life. He decided to become a physician. He quit, he went and became a physician. I called him up, and I go, "Can PAs practice independently?" And this is one person's opinion, obviously. He said -- he said, "I learned so much more in medical school to help synthesize what I did when I made a care plan." So I think that that's the way to do

that.

And for those of you who are lawyers -- and this might not be the best analogy, but you have paralegals that work for you. Are you going to let paralegals go to court and do cases? And the answer is probably not.

SENATOR LIU: And likewise, a mother who is looking for healthcare for her child may not be so inclined to go to a nurse practitioner or a physician assistant -- not to take anything away from them. But if there are no doctors available --

DR. PIPIA: They're an essential group. I kid you not, they're an essential group and we value them and they're part of the allied health team. But we just think that the doctor should be the one that's in charge of all of that stuff. He can't have five different people driving the car at the same time.

SENATOR LIU: Thank you very much.

Thank you, Madam Chair.

CHAIRWOMAN KRUEGER: Thank you.

I believe the Assembly is closed, and I just have one more question for the Senate.

So since three of you represent nurses -- so help me understand. They gave the numbers I think earlier today that there are something like 355,000 licensed nurses in New York State, 188,000 of them working as nurses. We all seem to agree there's a nurses shortage. And yet we also have this parallel phenomenon where we have hospitals filled with what's called traveling nurses who are also New York State residents, but they're making three times the amount as the nurses that I think are members of your unions working in our hospitals.

So something's very wrong with this picture, and I need help understanding. I asked the hospitals; they agreed there was something wrong, but they didn't give me an answer what we can be doing.

MS. SCHAUB: So can I -- I mean, I'll maybe start off and -- the agency phenomenon is also very significant in the nursing homes, so we're dealing with it in a number

of places.

And, you know, it's a beautiful business model for the agencies, right? They're essentially getting paid to fill the holes that they create. If you -- you know, you can recruit someone. If you're offering that kind of salary bump, of course even people might take leave from a permanent job to be able to go pay off their mortgage if they work six months at that kind of premium. Right?

So if you offer enough, people will come work for you. And then of course the institution where they were working has to maintain a minimum complement, and you can then bargain with them to bid up the price. It's been very inflationary, and it was funded -- it was funded in part by a lot of federal money during COVID that subsidized these very high traveling agency rates.

We have to figure out how to interrupt the cycle because otherwise it is a self-perpetuating cycle where, you know, again, they are doing well because they are

getting paid to fill the holes that they create by recruiting staff to work for temporary agencies.

We do think -- you know, of all the things we regulate in New York, nursing staffing agencies are very underregulated. We don't know who they are, we don't know how much money they make. So the Governor's proposals to regulate staffing agencies we do support, and we think that that is a start.

Other states -- there's a number of other states that have passed laws related to temporary staffing agencies, especially since COVID. Two other states allow for a cap in the amount of money that staffing agencies can charge. That's something that we could look at and maybe give authority to institute, certainly with the financial information that comes from registration.

Other states have regulated what they can put in contracts. For example, Illinois said a staffing agency can't prohibit a traveling nurse from taking a permanent job at the institution where he or she is placed,

which in some cases is part of the staffing agency contract.

And then we think there ought to be ways to look at incentivizing employers to invest in full-time jobs so that the financial calculation gets a little bit different.

The only other thing I'd say, you know, for many years we were fighting against staffing agencies because they've always been terrible for the union workers, and the employers have liked the flexibility. We're at a moment when the employers are not happy with the staffing agencies because of how much they're getting charged, and so we actually have a moment to I think come together with some meaningful approaches to try to invest in permanent jobs.

CHAIRWOMAN KRUEGER: So I know this isn't a three-minute question, so thank you for trying to answer it in three minutes.

MS. SCHAUB: Sorry.

CHAIRWOMAN KRUEGER: But I hope that we can all continue the conversation, because

we all know we need our nurses. We all know we need more nurses. We have nurses, but it's not working out right. So thank you.

And I believe I was the last one on the panel, so thank you all for being here today and for the work you do. Greatly appreciated.

And I'm going to call up our next and actually our last panel for the day, the American Cancer Society, Planned Parenthood Empire State Acts, Hospice and Palliative Care Association of New York State, and the National Hookah Community Association.

Okay, good afternoon. From my right, from my left -- let's start with my right, your left. Hi, Georgana.

MS. HANSON: Good morning -- or good afternoon. Good evening.

CHAIRWOMAN KRUEGER: Good morning?

(Laughter.)

MS. HANSON: I know, you've all been here much longer than I have.

CHAIRWOMAN KRUEGER: It's still afternoon.

MS. HANSON: Good evening. My name is Georgana Hanson. I use she/her pronouns. I'm the interim president and CEO of Planned Parenthood Empire State Acts. And I'm honored to be providing testimony to you today.

Planned Parenthood Empire State Acts represents the five New York Planned Parenthood affiliates who provide primary and preventive sexual and reproductive healthcare services to more than 200,000 individuals each year.

I know it's been a long day; I will work to be brief. I believe everyone here is aware of the devastating impact of the loss of our federal constitutional right to abortion this past summer. In this pivotal moment in the fight for reproductive freedom, we must continue to respond in bold and innovative ways, building a system of policies and care that is anchored in equity, where everyone who needs an abortion can truly access it.

While a proactive policy environment

is important, it is no longer enough on its own. There must be a significant financial investment in access to care. It is in that frame that I want to uplift three key issues for your consideration in the enacted budget.

First, we strongly support the provision in the Executive Budget that includes increased Medicaid funding for family planning and procedural abortion care. However, this critical investment must also include an increased reimbursement for medication abortion. Medication abortion comprises over 60 percent of abortions provided in New York Planned Parenthood -- and 60 percent of the abortions provided in New York Planned parenthood affiliates are medication abortions.

Over the past several years many states have raised Medicaid rates for abortion services. As a result, New York's reimbursement levels are significantly out of alignment with other access states, including Illinois and California. This is especially the case for medication abortion.

During testimony earlier today the Medicaid director stated that reimbursement for the medication used in medication abortion would not be increased. We understand current policy requires that medication is reimbursed at acquisition cost. But to be clear, diagnostic and treatment centers also receive reimbursement for a visit in conjunction with the medication. The cost of this visit is reimbursed hundreds of dollars less than what other states reimburse, and must be increased.

Upstate providers receive approximately $143 for the visit and $99 for an ultrasound if provided. In comparison, California, Illinois, and Vermont each reimburse over $530 for a medication abortion visit. Therefore, we urge that the enacted budget builds upon the Executive Budget proposal to also include a rate increase for providing medication abortion care to no less than $550.

Additionally, we ask that the enacted budget include $25 million in grant funding

for abortion providers and $1 million for abortion funds to increase access. Prior to the Governor's commitment to invest $35 million in access and security funding for providers this past summer, there's been no intentional investment in abortion access. We strongly support the $25 million investment proposed by the Governor to continue these critical grant funds.

Further, we ask that the Legislature include an additional $1 million to be directed to organizations addressing the practical support needs of people seeking abortion care in New York and ensure passage of the Reproductive Freedom and Equity Program. Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Next?

MS. CHIRICO: Okay. I think I'm on. There we go.

CHAIRWOMAN KRUEGER: Yes.

MS. CHIRICO: Good evening. Thank you, Chairs Krueger and Weinstein for allowing me to speak to the committee today.

My name is Jeanne Chirico. I'm the president of the Hospice and Palliative Care Association of New York State, and I have the privilege of representing the men and women who are working to ensure that the transition from this life to the next is a peaceful and celestial experience, as our acting commissioner mentioned this morning that he wanted the experience of childbirth to be a celestial experience.

And that word seems extremely apropos for the work that we do. And I'm going to use that in reference to the fact that I believe it's time again to call upon you to help our hospice and palliative care providers, our workforce, who has been working without the support of their state, except for the fact that last year you, the Assembly and the Senate, supported hospice workers by passing three bills that were meant to support access, quality and workforce. And I just would like to draw your attention to what's happened with those bills since, because there's still work to be

done.

In response to the lack of Department of Health representation and support, you passed unanimously a bill to create an office for hospice and palliative access and quality. This bill was then vetoed by the Governor, for reasonings that it was not included in the budget and that was the place to address it. So we're asking you to address this issue in this budget with a $400,000 allocation.

The second bill passed unanimously allowed hospices to provide care to individuals residing in adult living programs. Then, just days before the Governor signed that bill into law, the Department of Health released a "Dear Administrator" letter that confused and offered conflicting information. So right now no individual living in an assisted living program is being offered hospice services.

We're asking also that you consider the fact that you passed legislation and a

bill was signed to create a statewide advanced care planning campaign. The Governor then signed that law this past summer, and yet delivered an Executive Budget without any funding to help support that campaign. So we're asking for $2 million to begin this advanced care planning campaign that we hope can help lift New York State from last place in the country in hospice utilization, so that people begin to have the conversations that they need to have to help plan for their end of life, to make that a meaningful experience for them and their entire family.

I thank you for your time.

CHAIRWOMAN KRUEGER: Thank you.

Good afternoon.

MR. DAVOLI: Good afternoon, Senators, 4. Thank you so much for the opportunity to testify today. My name is Michael Davoli. I am the senior director of government relations for the American Cancer Society Cancer Action Network, ACS CAN.

On behalf of the 1.6 million cancer

survivors in New York State, I'm here to testify on behalf of two issues -- (1) related to cancer screening and (2) related to the tobacco issues included in the budget.

First, on cancer screening, I want to speak about the New York State Cancer Services Program. Every single year in New York State over 30,000 men and women will be diagnosed with just three cancers: Breast, cervical and colorectal cancer. All three of those cancers can be diagnosed at an early age through basic screening, and therefore lives can be saved.

Unfortunately, despite the incredible work of the CSP, it barely can scratch the surface of the need in New York State, serving only 18 percent of the eligible population. When Governor Cuomo cut the budget by 20 percent in 2017, more than 6,000 New Yorkers lost their ability to get screening the following year. We must restore those cuts from 2017 and bring the CSP's budget back up to $26.8 million in '23-'24.

Pivoting very briefly to tobacco, I'm just going to highlight a couple of statistics that some of you may or may not be familiar with. 28,200 -- that's the number of New Yorkers that will die this year alone from tobacco-related illness. That's more than the capacity of Madison Square Garden. That's like 10 times the size of The Egg just across the street.

26.7 percent of all cancer deaths in New York State are tobacco-related. Just think about that. If anything else -- guns, car crashes, suicide, anything else was causing 28,000 New Yorkers to die, it would be front-page news of the New York Post every single day until you act. We must act to curb tobacco use. We must stand up to the lies of Big Tobacco. We must address, advocates must address the questions that you have about these proposals. And we must work together to end the sale of flavored tobacco products, which are proven to hook kids generation after generation and drive inequities and health disparities, and drive

smoking rates within communities of color and lead to huge health disparities and deaths from cancer, smoking-related cancers within people of color, communities of color.

We must increase the tax on cigarettes because there has never been a more definitive way to drive down smoking rates and to keep youth from starting.

And finally, we must increase funding for the Tobacco Control Program. The TCP is how we help people quit and how we keep kids from starting in the first place.

Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Next.

MR. HUDGINS: Hi. Thank you. My name is Christopher Hudgins. I report my company, Al Fakher, on the board of --

CHAIRWOMAN KRUEGER: Can you pull your mic a little closer? Thank you.

MR. HUDGINS: Better? Thank you.

My name is Christopher Hudgins. I represent my company, Al Fakher, on the board of the National Hookah Community Association,

or NHCA. Appreciate the opportunity to share their views here today.

Founded in 2019, NHCA brings together hookah producers, distributors, sellers, hookah lounges, consumers -- really, the whole supply chain -- and community members to support the preservation of hookah's rich cultural traditions.

Hookah, also known as shisha, is a combination of a tobacco and a sugar substance such as honey or molasses, and it's comprised of only 15 to 20 percent tobacco. It is a heavy, wet, sticky substance that can only be smoked in a hookah pipe.

As has been the practice for hundreds of years, hookah is by nature a flavored product. As a result, a ban, the Governor's suggested ban on all flavored tobacco, would result in the ban of all hookah.

We ask that you exempt hookah from the flavor ban. You would be joining numerous jurisdictions that have done so for many of the reasons I'm about to discuss. Most recently, California made history and passed

a statewide flavored ban on -- a statewide flavored-tobacco ban, but they exempted hookah. And that's because the NHCA worked with legislators there to help them understand that the product has a cultural significance and it has a low youth usage rate.

We've worked with many other cities and states, including Colorado; Columbus, Ohio; Denver; San Diego; San Jose; Los Angeles. All of these cities have considered or passed flavored bans with hookah exemptions in them.

Hookah is a very small category in the tobacco space. It makes up only roughly 0.005 percent of nicotine sales here in the U.S., but it is a very important cultural practice that has existed for centuries. Middle Eastern, Armenian, Turkish, East African, Indian, Persian, Indonesian and many other immigrant citizens in the U.S. today enjoy hookah as a centerpiece for a cultural business and social gathering.

It has a very large population of use

here in New York, considering that many immigrants from these countries reside here. There are hookah lounges all over certainly the New York City area, but Buffalo, Rochester, Syracuse, Binghamton, Albany, Watertown -- all over. And these lounges serve as safe gathering spaces for many diverse ethnic and religious communities, each of them represented by small minority-owned businesses owned by immigrant or first-generation Americans with ties to regions where hookah originated or is practiced.

Hookah pipes are unlikely to be used by youth. They are several feet tall, they are expensive, they can take anywhere from 20 to 30 minutes to set up. It's not something you can hide in a backpack and smoke in school.

Federal data supports this. Each year the CDC and FDA put out youth usage rates for tobacco. The most recent one showed that just 1 percent of middle and high school students had tried hookah in the past

30 days -- and that's 10 times less than the number of those who vape.

For these reasons we ask that you exempt hookah from the flavored-tobacco ban.

Thank you.

CHAIRWOMAN KRUEGER: Gustavo Rivera.

SENATOR RIVERA: Thank you, Madam Chair. I just have a few.

Ms. Chirico, good to see you again. I wanted you to talk a little bit -- so we obviously passed this bill last year; I was very proud to do so. But you -- which you referred to earlier. But you said that no hospice and assisted living -- could you clarify what you said? Because I want to make sure if the bill in its implementation is not doing what we want it to do, then I certainly want to look into it more deeply.

MS. CHIRICO: Sure. Thank you for the question.

SENATOR RIVERA: Closer on the mic, please.

MS. CHIRICO: Oh, sorry.

I just want to clarify. Hospice is

provided in assisted living facilities, but we have a classification specific, as you know, to assisted living programs that have Medicaid funding, backing. And it required legislation that we receive to allow hospice in.

Unfortunately, the day before or two days before the Governor signed the bill into law, the Department of Health released a "Dear Administrator" letter that confounded the delineation between the hospice responsibilities and the Assisted Living Program responsibilities, to the point that it created a bureaucratic nightmare that it's taken months of questioning of the Department of Health. Now they have set a meeting for mid-March to begin the conversation of how to weed through the confusion that the DAL created.

SENATOR RIVERA: I want to be helpful with that, because we certainly want this bill to be implemented correctly.

MS. CHIRICO: Thank you.

SENATOR RIVERA: So let's make sure

that we follow up on that.

Mr. Davoli. Good to see you again, sir. Do you have a response to the gentleman at the end that talked about the hookahs? I share some of the concerns that were expressed. Certainly in my district in the Bronx there's certain communities that certainly --

(Overtalk.)

MR. DAVOLI: With all due respect, I would question the statement about the historical use of flavored hookah products. Flavorings -- the tobacco industry, the manufacturers themselves only talk about this in the past 60 years, some of the different flavors that hookah -- I mean, hookah has been -- for a thousand years. I mean, hookah has been something around -- I -- you know, I don't know if flavored hookah was being used for a thousand years. So I do question that statement.

But in New York City, the only hookah that is allowed is tobacco -- is hookah that does not have tobacco. So you could have

hookah that does not have tobacco in it, and that's a key distinction.

But, you know, from the American Cancer Society's perspective, our greater concern really is focusing on the broader use of tobacco use and focusing on whatever way tobacco is being delivered, we must be working to rid it of. So --

SENATOR RIVERA: Thank you.

Thank you, Madam Chair.

CHAIRWOMAN WEINSTEIN: Assemblywoman Paulin.

ASSEMBLYWOMAN PAULIN: Thank you.

Hospice, do you believe that we should eliminate the for-profit hospice?

MS. CHIRICO: We supported a bill that was passed in the Assembly and the Senate that would prohibit the establishment of additional for-profit hospices. Right now that bill helped to solidify the CON that is in place for hospices.

And unfortunately in the Executive Budget there were CON modifications to the hospice rules, and we're asking those

to be rejected as well, because it does open New York State to become proliferated with for-profit and venture capitalist hospices, like other states, like California.

ASSEMBLYWOMAN PAULIN: And we are a state that is -- underutilizes hospice services, to say the least. Ideas on how to make that better?

MS. CHIRICO: My first idea would be fund the advanced care planning campaign so that we can start --

ASSEMBLYWOMAN PAULIN: We're trying.

MS. CHIRICO: -- talking as a culture about these issues that are hidden too far -- deep in our families and cultures.

ASSEMBLYWOMAN PAULIN: I think that's it for me. Thank you.

MS. CHIRICO: Thank you.

CHAIRWOMAN WEINSTEIN: Senate?

CHAIRWOMAN KRUEGER: Any other Senators?

I have a question. Just following up on the American Cancer Society's comments that -- so in New York City where I come

from, the hookah bars are not providing tobacco products, they're a different product.

MR. DAVOLI: It's -- they cannot serve -- so flavored hookah is prohibited, unless it is -- does not contain tobacco. And that's -- there's the key. You can have hookah that does not actually have tobacco in it.

Now, I will fully admit, this is a little bit out of my expertise. I'm happy to get back to you with more information. But I just -- I don't want to misspeak here, so --

CHAIRWOMAN KRUEGER: So assuming you're correct, the Governor's proposal wouldn't change the story in New York City.

MR. DAVOLI: No, it would expand -- it would not change what's happening in New York City. It would expand this statewide and create the clarity.

CHAIRWOMAN KRUEGER: So then I want to ask the gentleman from the National Hookah Community Association, so do you really think this is going to be a big issue in New York

State, since I think the majority of the communities using hookah are New York City-based. And if life's been going on okay without flavored tobacco there, why should we worry it's a real problem outside of New York City and the rest of the state?

MR. HUDGINS: Well, I don't think things have been going okay, and I would say that --

CHAIRWOMAN KRUEGER: Try and get closer to the mic.

MR. HUDGINS: Oh, yeah, sure.

CHAIRWOMAN KRUEGER: Sorry.

MR. HUDGINS: I don't think that things have been going okay. I think certainly with that ban, which frankly happened before we were -- we existed -- partly why we existed, because many of these folks come from communities where interacting with government is not a good thing to do. So they're reluctant to speak up.

Hookah has been flavored for thousands of years. It was originally called mu'assel, which translates to "with honey." There is a

flavor presence. One of the most popular flavors today, and has been for hundreds of years, is "two apple," and that's because they originally would add slices of apple to it.

It's very popular, the flavored product, for people who practice this, and this is what they practice in foreign countries, and this is what they bring here.

It is true that flavored tobacco is banned in New York City. Lounges closed because of that. There are still lounges there. I question the enforcement there as well, which I think exposes some of the problems of taking this statewide.

The real fact is this is not something that is used by youth.

CHAIRWOMAN KRUEGER: And do you have any evidence that smoking hookah does not cause cancer?

MR. HUDGINS: I do not. I agree that hookah does contain tobacco. Hookah contains about 15 to 20 percent tobacco. A cigarette or vape comes up -- contains 100 percent

tobacco.

If you are looking -- if you're addicted to nicotine, you're trying to get a nicotine fix, a hookah is a terrible way to do it because it takes 20 or 30 minutes to smoke something this big.

Federal data also shows that hookah users only use it once or twice a month, predominantly. Over 90 percent only use it once or twice a month. It's not something you're going to go to for that nicotine fix.

It does contain tobacco; we're not hiding that.

CHAIRWOMAN KRUEGER: I once told a tobacco company that they should really think about coming up with products that don't kill their clients, because it's not that easy to replace them. So I might encourage people to use other products.

And my time is up. Thank you very much.

Any other questions?

CHAIRWOMAN WEINSTEIN: Oh, yeah, we have --

CHAIRWOMAN KRUEGER: Oh, Assembly.

CHAIRWOMAN WEINSTEIN: Assemblyman Blumencranz.

ASSEMBLYMAN BLUMENCRANZ: (Mic off.) Thank you.

Ms. Chirico, with Hospice, thank you so much for coming. I appreciate it, I appreciate everything that you do.

One thing that I find pretty interesting --

CHAIRWOMAN KRUEGER: I'm sorry, is your mic on?

ASSEMBLYMAN BLUMENCRANZ: Sorry.

One thing that I find pretty interesting is that it's commonplace that we don't separate palliative and hospice care. So what efforts do you think we should be taking as a body or in the budget to increase palliative care in other fields of medicine, including geriatrics, but across the field?

MS. CHIRICO: Thank you for that question.

One of the things I didn't have an opportunity to talk about was our request for

workforce funding. And contained within that is education about hospice and palliative care. And following up on the Hospice and Palliative Care Education Training Council that Governor Cuomo actually had put into place, which would include training even providers on the difference between hospice and palliative care and how to identify patients who would be appropriate for either, so that we can assure whenever somebody's seeing their primary care physician or an NP or a PA, that they understand the difference between the two and make referrals sooner in the trajectory of someone's illness.

ASSEMBLYMAN BLUMENCRANZ: Thank you so much.

CHAIRWOMAN KRUEGER: Assembly?

CHAIRWOMAN WEINSTEIN: Assemblyman Sayegh.

ASSEMBLYMAN SAYEGH: Thank you very much, Madam Chair.

On the hookah products and on cancer in general, as an educator, we've -- all of us as a society have always preached, you

know, to avoid the smoking and the impact on cancer, and alcohol and gambling.

But we go ahead and we follow and agree on policies and procedures to allow us to smoke cigarettes in general and allow us to smoke pot in New York, but to say you can't smoke a hookah.

I just want to show a testament that with my Middle Eastern background, for nearly 25 years, as was said, I probably smoke a hookah once, twice a month. Never saw it to be addictive. It is cultural for me. And from what I understand of the science, a lot less harm than cigarettes.

And I'm a little concerned because it really looks to a large community of Middle Easterners and South Asians and a broad spectrum around the world that smoke and enjoy hookah, that it's an unfair burden to say you can't smoke a hookah but you can smoke other products.

If you told me you had legislation where we agreed to ban all forms of smoking, I would say, well, this is a policy and this

is a procedure. But I really see this as unfair and it targets certain groups.

And more important, people I spoke to said, "You know what, even if you banned it, we know how to buy it, because it's available all over." So you lose the tax base. You have unmonitored products, and it becomes even more dangerous.

So I really think it's a little bit unfair to tie in the risk -- and I agree with you -- of cancer and the ills and cancer and really target one component of it.

MR. DAVOLI: Would you like me to respond or --

ASSEMBLYMAN SAYEGH: If I can have remarks from both --

MR. DAVOLI: Yes, yes, of course. Thank you so much.

Well, in -- listen, I want to emphasize this, this is why -- we're not talking about one group of people or another, we're talking about a product. And we're not talking about one specific product or another, we're talking about flavors.

Whether they are menthol cigarettes, flavored, you know, marketed towards women, using Virginia Slims to attract women and hook them on menthol cigarettes -- which, you know, women smoke menthol cigarettes nearly three times as much as men do.

Whether it's menthol cigarettes being given out all across communities of color in New York City and around the country, free, for decades, and advertisements in Black magazines to try to ingratiate themselves, the tobacco industry, with the Black community and trying to hook the community.

Whether it's, you know, the direct targeting of LGBT community populations in New York City with menthol cigarettes. These products are used to hook people.

So I am not advocating for any one specific type of tobacco. I'm talking specifically about saying that flavors are used to hook people, and we must do anything in our power -- and for all the communities in New York State.

We are the American Cancer Society.

My office is in the fourth floor of the Hope Lodge in Manhattan. There are cancer patients that come in there from many of your districts. I meet them in my office, coming in and out of the office every single day. They're from all over the State of New York. And they're dying, many of them, because of tobacco.

CHAIRWOMAN WEINSTEIN: Thank -- thank you. Thank you. Assemblywoman González-Rojas.

ASSEMBLYWOMAN GONZÁLEZ-ROJAS: Thank you all so much.

I do want to say for the record that I have -- I represent a district that has a large Arab community that -- and quite a number of hookah bars and lounges. So I completely support a ban on flavored tobacco, but I would support also an exemption for hookah because of the cultural significance in my community.

My question, though, is for Georgana. Thank you so much for being here.

I want to ask -- probe on the

Governor's proposal directly. Is there anything in this proposal that does provide for logistical support for people who need and are seeking abortion care, including travel, lodging, childcare, translation?

MS. HANSON: Are you speaking to the 25 million? The way in which the language reads in Aid to Localities connects that to providers. I think we -- which is part of the reason why we want to ensure that there's clarity that we could see grant money being used, not just to support providers in this moment increasing access, but to also be supporting the nonprofit entities that are delivering practical support to patients who need to seek -- you know, who are seeking abortion care in New York.

ASSEMBLYWOMAN GONZÁLEZ-ROJAS: Can you expound on like the lack of investment in these very practical supports? How does it impact the ability for us to provide abortion care for those who seek it?

MS. HANSON: Yeah, I think it's important to, you know, anchor ourselves in

the reality that even prior to the Supreme Court overturning Roe v. Wade this summer, that there were already barriers that prevented people from accessing abortion care, whether it was having to take time off of work, arrange childcare.

There are -- even in the great work we've done in New York to expand insurance coverage for abortion care, there are still individuals who lack coverage. And those barriers can push care out of reach. That's certainly the reality now, too, where we live in a country where 18 states have severely banned or restricted access to abortion.

ASSEMBLYWOMAN GONZÁLEZ-ROJAS: In the last couple of seconds, can you speak to the capacity needs of providers? What do appointments look like? How are you all doing in terms of providing that care?

MS. HANSON: I appreciate the question. I mean, I think we are living in a space where it's pretty dynamic, as states work to enact bans and restrictions.

But to be honest, care was challenging

before. I think you've heard from plenty of other providers today, and organizations representing providers, the cost of delivering care is increasing. It is hard to attract and retain staff. That is true especially for small safety-net providers like Planned Parenthood.

And so, you know, when we've seen underinvestment in care and, you know, that has throttled our ability to grow and expand to just meet current need, you can -- as you can hire providers and train them and bring them to capacity, you can increase access to care. When you can't do that, that impacts directly New Yorkers and others.

ASSEMBLYWOMAN GONZÁLEZ-ROJAS: Thank you so much.

CHAIRWOMAN KRUEGER: (Mic off.) Okay. Any other Assembly or Senators, speak now or forever hold your peace.

I want to thank you all very much for coming and testifying today. I believe this now concludes the public hearing on the health budget for New York State.

Come back tomorrow morning at 9:30, and the topic will be housing. And then I believe there is a second hearing tomorrow, on workforce development, starting at 2 o'clock or later.

So thank you all very much.

(Whereupon, the budget hearing concluded at 6:16 p.m.)