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

JOINT LEGISLATIVE HEARING

In the Matter of the
2014-2015 EXECUTIVE BUDGET
ON HEALTH AND MEDICAID

Hearing Room B
Legislative Office Building
Albany, New York

February 3, 2014
9:34 a.m.

PRESIDING:

Senator John A. DeFrancisco
Chair, Senate Finance Committee

Assemblyman Herman D. Farrell, Jr.
Chair, Assembly Ways & Means Committee

PRESENT:

Senator Liz Krueger
Senate Finance Committee (RM)

Assemblyman Robert Oaks
Assembly Ways & Means Committee (RM)

Senator Kemp Hannon
Chair, Senate Committee on Health

Assemblyman Richard N. Gottfried
Chair, Assembly Health Committee

Assemblywoman Joan L. Millman
Chair, Assembly Aging Committee

2014-2015 Executive Budget
Health and Medicaid
2-3-14

PRESENT: (Continued)

Assemblyman Michael Cusick

Senator Diane Savino

Assemblyman Kevin A. Cahill

Senator Gustavo Rivera

Assemblywoman Ellen Jaffee

Senator Malcolm Smith

Assemblywoman Joan L. Millman

Senator Ruth Hassell-Thompson

Assemblyman Andrew P. Raia

Assemblyman Andy Goodell

Senator Velmanette Montgomery

Assemblyman Clifford Crouch

Senator Catharine M. Young

Assemblyman Phil Steck

Assemblyman Joe Lentol

Senator Elizabeth O'C. Little

Assemblywoman Aileen Gunther

Senator Martin J. Golden

Assemblywoman Aileen M. Gunther

Senator Cecilia Tkaczyk

Assemblyman David G. McDonough

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PRESENT: (Continued)

Assemblyman Raymond Walter

Senator Terry Gipson

Assemblyman Thomas J. Abinanti

Assemblyman Jeffrion L. Aubry

Assemblywoman Linda B. Rosenthal

Assemblyman Andrew P. Raia

Senator Brad Hoylman

Assemblywoman Shelley Mayer

Assemblyman Edward P. Ra

Assemblyman Alfred C. Graf

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CHAIRMAN DeFRANCISCO: Good morning. Welcome today to the hearing that we're having in the series of joint Senate Finance/Assembly Ways and Means hearings. The topic today obviously is health and Medicaid.

And pursuant to the State Constitution and Legislative Law, the fiscal committees of the State Legislature are authorized to hold hearings on the Executive Budget proposal. And we mentioned what this hearing was about.

Following each presentation, there will be some time for questions allowed from the chairs of the various committees as well as other legislators.

We have an incredibly long calendar today. And I'm wearing this orange tie for two reasons. One, the Syracuse University basketball team will be number one when the polls come out today, after beating Duke.

(Applause.)

CHAIRMAN DeFRANCISCO: And more importantly, they play Notre Dame at 7 p.m.

tonight. Remember that time. Even the early speakers.

CHAIRMAN FARRELL: I have a 6 o'clock meeting that I have to make, so the number is 6:00, not 7:00.

CHAIRMAN DeFRANCISCO: Okay. All right. And the members of the Senate -- and then I'll turn it over to Denny Farrell -- are the chairman of the Health Committee, Kemp Hannon, in the Senate. Diane Savino is over here. And I've got to introduce the Most Valuable Player of the Super Bowl, Malcolm Smith.

(Laughter.)

SENATOR KRUEGER: And, I'm sorry, for the Democrats, we're joined by Gustavo Rivera; I'm Liz Krueger, the ranker; and Terry Gipson in the front row.

CHAIRMAN FARRELL: Our chair of the Health Committee, Assemblyman Gottfried, is with us, Assemblyman Cahill, Assemblyman Cusick, Assemblywoman Millman, Assemblywoman Jaffee, and Assemblyman Oaks to tell us his members.

ASSEMBLYMAN OAKS: Yes, we're also joined by Assemblyman Goodell this morning.

CHAIRMAN DeFRANCISCO: Thank you.

Just one last thing. The legislators know this who have been here before, but they've got 7 minutes on the first round to ask questions. We may give a little leeway to the chairs. And then if you want to ask more questions, we'll put you on at the end, so at least everyone gets a chance to ask some questions before it gets too late.

So the first speaker is Dr. Shah, the Commissioner of the Department of Health. Welcome.

COMMISSIONER SHAH: Thank you. Good morning, Chairmen Farrell, DeFrancisco, Hannon and Gottfried, Senators Rivera and Breslin, and Assemblymembers Raia and Oaks, and all of your colleagues here today. I am Dr. Nirav Shah, Commissioner of the New York State Department of Health, and I am pleased to join you today to share Governor Andrew Cuomo's Executive Budget as it relates to the Department of Health.

It's been three years since the state embarked on its historic Medicaid reforms, led by Governor Cuomo's Medicaid Redesign Team. As discussed in his State of the State address, New York has achieved remarkable improvements in Medicaid as a result of the work of the MRT, both in terms of quality and reduced expenditures. In the first year alone, New York's taxpayers saved $2.2 billion. Over the next five years, we anticipate that the federal government and the state will save a total of $34 billion as a result of these reforms.

But our work is far from done. To meet the goals of the Triple Aim -- better population health, better quality and lower cost -- we must build on these successes and continue to transform the entire healthcare delivery system of New York. And the challenges we face are substantial. In particular, our health care delivery system is imbalanced. It relies too heavily on inpatient care, emergency room services, and nursing home care and not enough on primary

care or community-based services. We have struggling safety net providers throughout the state, and some are in danger of closing and placing even basic healthcare access at risk. Nowhere is this more pronounced than in Brooklyn. Several hospitals there are in dire financial straits and on the verge of closure.

Our roadmap to meet these challenges and achieving the vision of the Triple Aim is the State Health Innovation Plan -- the SHIP, we call it. The plan was developed last year by the state in partnership with stakeholders from across the system, with groups representing consumers, payers and providers. The SHIP recognizes the diverse needs, attributes and resources of New Yorkers across the state and concludes that regional innovation is required to achieve optimal health for all New Yorkers.

The state will establish 11 Regional Health Improvement Collaboratives, or RHICs, which will actively engage stakeholders, analyze data and develop strategies that

align healthcare resources with population health needs. The work of the RHICs will be based on the best practices identified by the Finger Lakes Health Systems Agency, a successful model of regional planning for almost two decades in the Rochester region.

They've done a lot in Rochester. They now have been scoring in the top 10 percent nationwide in terms of health system performance as measured by the Commonwealth Fund's local report card. They have the lowest overall Medicare spending rate in the nation, with reductions in acute hospital inpatient use and among the highest quality anywhere in the state.

The promise of regional planning is to take what we've learned in Rochester and to spread it throughout the state.

But the transformation of New York State's health system requires federal support as well. We've asked them to approve our Medicaid Redesign Team waiver amendment submitted 18 months ago. The waiver will continue on the work of MRT by

reinvesting $10 billion in federal Medicaid savings back into our healthcare delivery system over a five-year period. Of that amount, half a billion dollars will be used to support Health Homes and $2.1 billion will be directed to improving primary care, behavioral health and workforce initiatives.

And the third component of the waiver is the state's Delivery System Reform Incentive Payment Plan, or the DSRIP plan, which aims to reduce avoidable hospital use by 25 percent over the next five years and help to rebalance the state's healthcare delivery system and stabilize the healthcare safety net.

In particular, this funding will allow the safety net providers to downsize unneeded inpatient capacity and adjust their mix of services while providing lower-cost, higher-quality alternatives to emergency room care. In short, the waiver is fundamental to our transformation agenda.

But federal funding is not enough. The feds will not allow waiver funds to be

used for bricks and mortar. Therefore, Governor Cuomo's budget will establish a $1.2 billion Capital Restructuring Financing Program, which will pay for construction projects that enhance quality, financial viability and efficiency of the healthcare delivery system.

The budget will also expand eligibility for the Health Facility Restructuring Loan Pool, currently only available to general hospitals, to include not-for-profit nursing homes and diagnostic and treatment centers. In addition, the budget authorizes the creation of a pilot program that would allow up to five corporations approved by the Public Health and Health Planning Council to invest private equity in hospitals.

Taken together, these programs will enable the state to assist facilities and help them to empower themselves in restructuring their operations and finances so they can improve the healthcare delivery system and ultimately improve patient care.

Improving patient care will also require integrating the Statewide Health Information Network-New York, the SHIN-NY, with New York's All-Payer Claims Database, the APD. The SHIN-NY is a secure network that shares clinical patient data so that healthcare providers responsible for a patient's care will know the patient's medical history. The All-Payer Claims Database stores data from all major public and private payers in one integrated network. And taking these two networks together will result in more coordinated care, higher-quality care, and lower-cost care for New Yorkers. It will give us the population health tools we need to transform New York State.

In his Executive Budget proposal Governor Cuomo identifies a bold new approach to the organ donation crisis referred to in his State of the State address. The department will engage in a public/private partnership regarding the operation and promotion of the New York

Donate Life Registry.

New York is also leading the nation and the world in committing to the end of the AIDS epidemic. Today approximately 130,000 New Yorkers are diagnosed and living with HIV or AIDS. We are still the center of the epidemic. But our efforts to end the AIDS epidemic have combined prevention, testing and effective treatments to produce a significant drop in new cases.

In 2013, preliminary numbers show that we had only two cases of mother-to-child transmission out of over 240,000 live births. This is incredible.

The success of our programs reflects our close and productive working relationship with strong community partners who have long been a voice for these vulnerable populations.

I'd like to now spend a few minutes updating you on the activities of the department since we last met.

As you are all aware, I am still in the process of reviewing the science on

hydrofracking. I am sure that the science will be reflected in my final recommendations, but the process must be done carefully, deliberately, and with objectivity.

In October, New York State opened its Health Plan Marketplace, the New York State of Health, allowing New Yorkers to shop for and enroll in high-quality affordable health plans. Health plans of the New York State of Health are on average 53 percent less expensive than what individuals paid for last year. Sixteen health insurers are offering health plan coverage to individuals, and 10 also offer plans to small businesses throughout New York's Marketplace. As of today, over 650,000 people have completed applications on our marketplace, and 380,000 are enrolled in high-quality health plans.

Last year we worked together to pass Aidan's Law in the enacted budget, which added a test for adrenoleukodystrophy, a rare genetic brain disorder. Today that

test has been successfully added to our newborn screening panel, bringing to a total of 46 the numbers of tests in New York's panel. We are the first state in the nation to screen for this condition.

Opioid addiction and abuse have become major public health problems. Thanks to you, our partners in the Legislature, and the adoption of the I-STOP legislation last year, the department has been a leader in the fight against prescription drug abuse. Since the law took effect on August 27th, the Prescription Monitoring Program has processed more than 6 million searches from over 65,000 healthcare professionals. And this is up from only half a million searches by 6,000 providers over the prior 3½ years. The numbers of individuals engaged in doctor shopping have dropped by 75 percent. Without a doubt, I-STOP is something that we can all be proud of.

Many of the people who successfully rolled out the I-STOP program are working with the same supervision in Governor

Cuomo's plans to allow the advancement and research of medical marijuana in a framework that prevents diversion and abuse. We have actively engaged hospitals around the state, have had several meetings and ongoing meetings planned for the next few months, and there is a lot of interest in this program.

The Executive Budget reflects Governor Cuomo's commitment to serve the taxpayers in New York while making strategic investments and reforms in our healthcare delivery system that will help all New Yorkers. The Department of Health looks forward to working with you closely to make sure that the interests of the people of New York and the healthcare delivery system continue to advance throughout the year.

Thank you. I'm very happy to answer your questions.

CHAIRMAN DeFRANCISCO: Thank you, Doctor.

The first questioner is the chair of the Health Committee in the Senate, Senator

Kemp Hannon.

SENATOR HANNON: Good morning, Doctor. Thank you.

I want to begin with some broader-based questions, and when my colleagues have gone through their thoughts and shared with you, I'll come back and get some more detail.

And so I'd just ask you to comment on this. One of the greater news stories of the whole year, obviously, has been the implementation of the Affordable Care Act in New York State. And to a large extent, New York has been successful in the mechanics and has rolled that out well.

But I was very surprised in the budget proposal to read a request for appropriations in terms of several millions of dollars. And I was very surprised because the representation to the Legislature had been that the exchange in New York would be run on a self-sustaining basis when the federal subsidies had been exhausted. And I can just ask you, what

happened to that and is there really an expectation that New Yorkers are going to have to subsidize this federal program?

COMMISSIONER SHAH: So as you know, the exchange has been funded by over $400 million of federal funding to date, and we anticipate continuing to receive federal funding. Perhaps even an application may go in in February for the next round. And other states have successfully managed to continue to fund their exchanges through this year.

We're looking for about $150 million total, $28 million from HCRA and other sources, that will help continue to fund the exchange. There are startup costs associated with the exchange. As you know, with enrollments so high and so fast, we've had to hire more people in some ways than we anticipated.

But ultimately it will be self-sustaining to the extent that the funding required to fund the exchange does not require new funds. It's just as folks

have expanded their eligibility to insurance plans -- for example, the HCRA funds grow -- those fundings are being used. It's been within our projections, within our rounding error.

To the extent that ultimately we'll have to be --

SENATOR HANNON: One hundred fifty-eight million is a rounding error?

COMMISSIONER SHAH: When you have a $125 billion healthcare delivery system in New York and we enroll 350,000 people in the first few months alone -- we're not even up to March 31st -- a few million here and there, $28 million is within the rounding error of a $6 billion HCRA pool. That's the rounding error. It's a lot of money, it is real money, but it is needed for successful implementation of the exchange and continued enrollment.

SENATOR HANNON: I have concerns about the self-sustaining aspect of it. I have major concerns about tapping into what is known as HCRA, which is the Health Care

Reform Act, which was designed to help the providers of our healthcare system in-state.

And not only do I have concerns about doing it for the exchange, because it's a change in course, I then have concerns about taking money out of HCRA to the tune of $75 million to $95 million a year for information technology that may be otherwise provided in any event. So those are big concerns. And that's all to do with the State of New York's information exchange implementation.

One of the other things of great concern to me is the waiver. Not because it's -- frankly, the state has earned it. The state has saved money. The federal government should share it. But this is an elusive waiver which about 12 months ago changed its purposes. And you repeated again, and I don't know the world of New York healthcare understands it, but it's designed to cut hospital admissions by 25 percent in five years. And Medicaid Director Helgerson when he made that

presentation said 50 percent over 10 years.

So I don't know, in the throes of concern that we're going through about hospitals in this state -- what's going to be kept open, what's partially going to be closed, what's entirely going to be closed -- how that meets up with cutting that many admissions to hospitals. And so I think there's a need to have a greater public discussion as to where we're going with that.

The last general point I want to make is the oft-touted and unexplained global cap. There is in last year's budget, the years before, the implementation of a cost-holding measure. But I think it is time, in our third year of implementing this cap -- maybe it's the fourth year, depending on how much we've reached back -- is explaining what the cap is. Explaining where the actual costs are going to be saved, explaining where the increase -- there's almost a 4 percent increase in Medicaid -- where that money is going to go,

who's going to receive that money, how it's going to be allocated. And in the same way looking for the previous 12 months as to what happened to the increases.

The whole concept of the cap has really been put in many minds into doubt when the state budget absorbed a $1.2 billion cut in federal developmentally disabled reimbursement last spring. We were told we had done so well with the cap we could just accept it. Well, I'm not so sure anybody saw the shells as they moved around. But I think in terms of budget credibility and policy, we need to have a far better explanation than what we've had before.

And let me point out when the Legislature asks for an explanation -- and I see what's given to our fiscal staffs -- I don't believe PowerPoints are sufficient. I know it's a convenient mode of communication in this modern world, but when you're doing a budget with the large amount of money that you're talking about, I think we need more than PowerPoints.

COMMISSIONER SHAH: We'll be sure to brief you appropriately.

CHAIRMAN DeFRANCISCO: Thank you, Senator.

We've been joined by Senators Cathy Young and Betty Little.

SENATOR KRUEGER: And Ruth Hassell-Thompson and Cecilia Tkaczyk.

CHAIRMAN FARRELL: And we've been joined by Assemblyman Phil Steck and Assemblyman Joe Lentol.

ASSEMBLYMAN OAKS: As well as Assemblyman Raia.

CHAIRMAN FARRELL: First to question, Chairman Gottfried.

ASSEMBLYMAN GOTTFRIED: Thank you.

Good morning, Commissioner. You mentioned in your testimony the Governor's proposal relating to medical marijuana activating the 1980 statute. I have a few questions.

You have said that the medical marijuana initiative will be clinical research. Is that what is usually meant,

meaning research on the safety and effectiveness of a drug or a therapeutic intervention with randomized and control groups, specific outcomes being measured and follow-ups? Or is it research on how to run a production and distribution system?

And, you know, the 1980 law is rooted in getting the approval of the FDA, the DEA or the National Institute on Drug Abuse. Is there any evidence that they will approve, quote, clinical research, unquote, on the effectiveness of a production and distribution system? And how will the department get the specialized strains of marijuana and nonleaf products that many patients need and pay for all this?

And you mentioned -- it seemed like you were saying that the I-STOP system was going to apply to the medical marijuana system. But the I-STOP statute is dependent on a prescription, and under federal law it is illegal to write a prescription for a Schedule 1 controlled substance. So I don't understand how I-STOP can be used here

without statutory amendment.

And I guess my bottom line is given the Governor's recognition of the need for action here, will the Governor be willing to work with the Legislature to enact really comprehensive and workable legislation in this area?

COMMISSIONER SHAH: Thank you for your questions.

Starting with the research, research does not always have to be a randomized control trial. Research can also involve things like observational studies, pre, post. You follow a patient over time, you understand their pain scores and other scores at the baseline and see how they change over time. So research can be thought of broadly in many ways.

And since 1999, the federal government has approved 15 INDs, investigational new drug applications, for medical marijuana use. So the feds have a process in place. They have worked with numerous parties to actually begin and

engage in research of this Schedule 1 substance.

The opportunity of doing this under the existing law is that this will be part of the therapeutic continuum offered to patients. Hospitals around the state are very excited, under federal guidance, according to the law --

ASSEMBLYMAN GOTTFRIED: Excuse me. I apologize for interrupting. But will the research be therapeutic research on the effectiveness of the drug? Or is what is being researched how to design a production and distribution system?

COMMISSIONER SHAH: The former. The former. Not the latter. Not about a distribution system. The research is about the effectiveness. Do patients with certain end-stage cancers benefit? If so, how much? What are the bounds of the kinds of patients that benefit? How do we continue to provide evidence showing that this should be part of the armamentarium of drugs that physicians prescribe? Not only in New York, but

ultimately our goal is that the evidence that we provide will be of such high value and done at the statewide level will be enough for the country.

ASSEMBLYMAN GOTTFRIED: Okay. I don't think that's what the Governor said in his State of the State speech, but okay.

COMMISSIONER SHAH: Speaking to I-STOP, what I mentioned in my remarks was that the same folks who had been working on I-STOP are also the same folks who will be working on some of this program, parts of this program. So we are confident that we have the right people who have a track record of success, who know how to work with state, federal and local partners from a law enforcement side, from a hospital side, from a distribution side to make sure that this program rolls out effectively on time.

As you remember, I-STOP rolled out two months early before its deadline. So we're very aggressive of moving forward with the existing statutes we have on the books to make this a success.

And as you may have heard, Larry Schwartz just last week on the radio mentioned that we are willing to work with the Legislature with whatever is presented to the Governor on his desk. We are working with the tools we have at hand, which is this 1980 bill, and we are going to make it work. If there are other things that appear on our desk, we will absolutely make them work as well.

ASSEMBLYMAN GOTTFRIED: If I can focus in on that last reference, are you saying that you are willing to work with the Legislature to pass a bill? Or are you saying that if the Legislature passes a bill, you're not committed to vetoing it, you'll look at it?

COMMISSIONER SHAH: I don't want to talk about hypotheticals because I don't have a bill in front of me. I've seen other versions of bills, but I need to see one that passes both houses. And to the extent that we have something that we think will work very well today, I'm focusing all my

energy on making sure that we have the medical marijuana program up and running within a year to meet New Yorkers' needs.

The problem is other programs that look for other distribution systems or other ways of setting up regulatory structures may not be out there and up and running within a year. My goal is to get this up and running as soon as possible. And using federal sources for product, we can get it up and running within a year.

ASSEMBLYMAN GOTTFRIED: And patients who need something other than basically street-grade dried leaf, how will that be obtained?

COMMISSIONER SHAH: We will work with whatever strains the feds have available. By law, they have to provide whatever is needed. So to the extent that there is a greater need, it's incumbent on the feds to make sure that the need is met.

There are other strains. For example, NYU is recruiting patients, children with a rare form of epilepsy who

need a different strain that is available by the feds that you may have heard of. And there are other protocols around which are enrolling patients for other research protocols.

ASSEMBLYMAN GOTTFRIED: Is the federal government producing oil extract of the so-called Charlotte's Web strain? Is that what you're saying?

COMMISSIONER SHAH: Not that I'm aware of. Not that I'm aware of.

ASSEMBLYMAN GOTTFRIED: That's what I thought. Okay.

The budget seems to propose that it will be illegal for Medicaid to pay for a prescription for essentially the off-label use of a drug. It says it won't pay if a drug is being prescribed for a condition other than one that is a medically accepted indication as defined by federal law, which I think is a long way of saying off-label.

Now, doctors prescribe drugs for off-label use thousands of times a day in this state quite legally. Is there a

growing body of medical opinion seeking to outlaw off-label prescribing of drugs? And is the administration proposing only to apply this proposition to Medicaid patients and their physicians, or might the administration try to prohibit my doctor from prescribing a drug for an off-label use since my prescriptions are paid for by public employee benefits?

COMMISSIONER SHAH: That's a good question. You know, remember that today medical marijuana is a Schedule 1 substance.

ASSEMBLYMAN GOTTFRIED: Excuse me. This isn't a medical marijuana question. This is a question about drugs that are being prescribed for an off-label use. For example, a drug that may have been tested on adults but has not been specifically approved for children. Or drugs that may have been tested and approved for one kind of cancer but doctors every day prescribe it for other kinds of cancers.

There are an endless list of examples of uses of off-label drugs. The budget

proposes that this would now be illegal under Medicaid. There is language in that paragraph about prior authorization, but there are no criteria for the prior authorization. And the language doesn't say that if you get prior authorization that overrides the prohibition on Medicaid paying for the prescription.

So my question is, where does this come from, what is the body of medical opinion that supports this prohibition, and is the administration looking to extend this prohibition to public employee health benefits?

COMMISSIONER SHAH: Great question. So to the extent that when the FDA approves a drug for a given indication, Medicaid automatically covers it. That's the standard. Oftentimes physicians will use medications off-label -- that means, for example, it was proven in adults, hasn't been proven in kids, they'll cut it in half and given a half a pill to a kid, something like that. Right?

To the extent that that's a practice over time that has helped many patients, it's been helpful. But now what we're seeing is that, more and more, oftentimes when a pharmaceutical does get an indication, they try to get as broad an indication as possible. They want to cover as much as patients as possible.

When there are instances of off-label use, more and more what we're seeing is that it is actually not necessarily in the interests of the patient. There may be side-effect profiles, there may be other drugs that should be tried first. And what we're trying to do is to try to not practice medicine but try to make sure that we raise the standard to which medicine is practiced, so that patients are protected.

If there is an indication, pharmaceuticals can absolutely go back to the FDA and extend what they're allowed to prescribe for, extend the indications. And over time where before we were at a stage early in our pharmaceutical history where we

didn't have so many choices, we have so many choices now. There are so many opportunities for high-quality patient care through pharmaceuticals for patients that are on-label.

And unfortunately this can lead to harm, this can lead to an epidemic of children being prescribed highly brain-active antipsychotic medications, for example. And that has been harmful to our children as a real example, off-label use.

So the extent that we want to curb that use, we will see the implications and we will right-size the policy as needed.

ASSEMBLYMAN GOTTFRIED: Why not use the Clinical Drug Review Program or something like it to identify drugs that have that kind of harmful use and apply prior authorization to those drugs?

But that's not what the budget language does. The budget language prohibits Medicaid from paying for any off-label prescription no matter how beneficial. Why would you do that?

And again, my other question is are there people in the administration proposing to subject public employees to that same restriction through their health benefits?

COMMISSIONER SHAH: I can speak to the former. I can find out about the latter with the public employees plan.

To the former, we know that as we make policy, policy is not just a one-and-done situation. When we rolled out our whole move of the prescription drug benefit into managed care, October of 2012, we stopped and took a back step and said with antipsychotics we need to rethink how we do this transition. And in real time we stopped, we addressed it, and we fixed it before any patients were harmed.

To the extent that our intent is to protect patients, to stick to the indication, we will continue down this pathway. To the extent that we need any course corrections, we are willing and able to make them in real time.

ASSEMBLYMAN GOTTFRIED: Okay. Thank

you.

CHAIRMAN DeFRANCISCO: The next questioner is Senator Savino.

SENATOR SAVINO: Thank you, Senator DeFrancisco.

Good morning, Dr. Shah. Returning to the subject of medical marijuana, as you know I am the chief sponsor in the Senate on the Compassionate Care Act, as Assemblyman Gottfried is in the Assembly.

A couple of points that I would like you to address. I heard in your testimony the issue of establishing a statewide research program, and you addressed some of that in your response to Assemblyman Gottfried. But I'm curious as to why we think at this point in the history of medical marijuana we need to do a research program of any kind when 21 other states have been doing it.

In fact, there are other nations -- you know, there are other countries besides the United States. There's been extensive research in Israel, there's been extensive

research in Canada, extensive research in Ireland. So we don't really need to research the value of medical marijuana as a treatment alternative for people with particular conditions.

What we need to do is establish a regulatory model in New York State that will allow for the creation of a legal grow industry so that we have access to a product that is clean, that is multivaried. Because as we know, not everybody smokes medical marijuana. In fact, most people don't. So we need to be moving in that direction, not starting as if no one has ever done this before, reinventing the wheel.

We are on the verge of being -- I think we actually are now the only state short of Delaware on the East Coast that doesn't have a medical marijuana statute. So if you're interested in research, perhaps you just, you know, pull out the old E-ZPass and go to Jersey or go to Connecticut or go to Massachusetts or fly to Colorado if you want to do some research.

I think the department would be -- your time would be better spent working on a regulatory structure that would implement the Compassionate Care Act that Assemblymember Gottfried and I have so that, as you pointed out, you want to be in front of it, not behind it. You want to get there faster rather than later. Let's work on that process so when we do get the legislation passed and the Governor signs it, you're already way ahead of the game in the implementation process.

COMMISSIONER SHAH: Thank you, Senator. My goal is yours, to protect the health and safety of New Yorkers and offer options of proven therapeutic benefit. And because of the existing statute, that is the only mechanism I have today to advance the process.

To the extent that safe, clean, unadulterated product is going to be primary to making this product work, we're looking to the feds for the sources. To the extent that we're using a medical model with

hospitals providing the product, that's another way where we can, within the existing therapeutic relationship of the doctor and the patient, advance this model.

The science is actually changing. You know, 10 years ago versus today there are many more drugs out there that help patients. In fact, when we first started down this pathway, we got a lot of feedback from ophthalmologists saying: Absolutely not, don't allow medical marijuana for glaucoma. There are new treatments available that help, so please don't go down that pathway. To the extent that --

SENATOR SAVINO: Dr. Shah, with all due respect, most of those drugs that are now available are highly addictive and dangerous. This is not about picking one drug over the other, this is about allowing doctors and patients to make the best decisions for themselves, depending on how they want to treat the condition that they have.

COMMISSIONER SHAH: I agree.

SENATOR SAVINO: Whether or not ophthalmologists want to utilize medical marijuana as opposed to an alternative drug should be a decision that they make. We don't need to take tools out of their toolbox.

And we don't do that with any other drug. Two minutes ago you testified about restricting the use of off-label drugs. Well, there seems to be an inconsistency here.

We don't have a lot of time, and I know a lot of my colleagues want to talk about the healthcare issues and the hospital closings in Brooklyn. I want to focus on this issue because I think your department is going down the wrong path and that in many respects you're wasting your time.

It is inconceivable that the federal government is going to give New York State a waiver to allow hospitals to dispense medical marijuana. It's inconceivable. It has not been done in any other state. In states that have a legal medical marijuana

statute and a program up and running, the federal government has not given them any leeway. I cannot imagine a scenario where they would do that for New York.

I am sure you are aware of and have a copy of the August 2013 memo from the Justice Department which dictates the type of things you need to do in a state that has a medical marijuana statute to avoid the federal government coming in and raiding you. Everything that you've been asked to work on would subject us to a consistent raiding process by the federal government.

So what I would again emphasize is take the time that you have, ask your department to begin to develop regulations that will promulgate the Compassionate Care Act so when we do pass it and the Governor signs it, that process will be that much further down the road of getting a legal medical marijuana industry in this state. Because we've seen in other states the regulatory process has been a stumbling block.

There are patients who are suffering right here in New York. There are families with children who cannot wait for us to do this right. You said yourself that there's no way to get this Charlotte's web strain that will help children with Dravet syndrome, and so those families are moving to Colorado --

COMMISSIONER SHAH: Except at NYU.

SENATOR SAVINO: Yeah. They're going -- they're moving -- because, you see, you can't bring a product into New York State -- that's also what the Justice Department has said -- even if you bring it from a state that has a legal medical marijuana program. So unless we're growing it here in New York, which we can't, where are we going to get it from?

So all I'm suggesting is let's do this the right way. You work on the regulations on our bill, and then we'll get there much faster so that when we can start growing, we're able to provide real relief to patients. We cannot continue to lose

people to other states. They're moving to Colorado, they're moving to New Mexico, they're moving to Washington State because they can't wait for New York anymore.

COMMISSIONER SHAH: Thank you, Senator.

SENATOR SAVINO: Thank you.

CHAIRMAN FARRELL: Thank you.

ASSEMBLYMAN OAKS: We've been joined by Assemblyman McDonough.

CHAIRMAN FARRELL: Next to question, Assemblyman Cusick.

SENATOR KRUEGER: And we've been joined by Senator Brad Hoylman.

CHAIRMAN FARRELL: Assemblyman Cusick.

ASSEMBLYMAN CUSICK: Thank you, Mr. Chairman.

Welcome, Commissioner.

Commissioner, in your testimony you mentioned I-STOP. And I just wanted to say thank you to the Department of Health. It has been a big success since it was implemented in August.

One question I have on I-STOP is I know that Senator Lanza and I had sent you a letter earlier last week concerning I-STOP has been very successful and, like anything, with success there comes some circumstances that we see now after the success of the database. Particularly in Staten Island and areas that are surrounded by other states, people are now going to New Jersey, Pennsylvania, surrounding states to get these drugs.

With the lack of a federal database, is it possible for the State of New York to now look into joining into agreements with New Jersey, Connecticut, and other states? I know that there are similar databases, of course not as good as New York State, but there are similar databases like I-STOP in the other states. Can we join and share information?

COMMISSIONER SHAH: You know, that's a great suggestion. To the extent that I don't think we can share individual-level information because of the statute that

exists today in terms of privacy and security of the data. But there are many ways that we can coordinate, and I will follow up with my colleagues in those states, in our certain neighboring states, to see what more can be done.

At the federal level the health commissioners get together and we talk about problems, and this is one that we talk about regularly. And one of the major initiatives of this group this year is around prescription drug abuse. And I have signed a pledge to work on this problem and continue to advance New York's position in improving treatment options for patients and stopping diversion and abuse as much as we can, absolutely.

ASSEMBLYMAN CUSICK: I appreciate that. Because I know the district attorneys are very concerned about this, law enforcement is very concerned about it. And it is the next issue in this ongoing epidemic. And it would be helpful if we could start figuring out what we could do in

the State of New York to help tie that part of this epidemic.

Also on the issue of I-STOP, we know that it has worked. I'm hearing from a lot of doctors in the state saying that at first they were a little leery about it, but I think people are starting to realize that it helps them. Will there be a report, a six-month report or some type of report as to exact numbers on where we are with this?

COMMISSIONER SHAH: Maybe we'll try to do a press release today.

ASSEMBLYMAN CUSICK: I like that. Thank you.

COMMISSIONER SHAH: Get to work, guys.

(Laughter.)

ASSEMBLYMAN CUSICK: Also, too, I want to switch gears a little bit with Sandy. With Sandy and the aftermath of Sandy, there were quite a few areas, particularly Staten Island, Long Island, that the areas that were hit, that's where the hospitals were. That the hospitals were

in flood zones.

And has there been a study made by the state since Sandy on areas that the hospitals are in the actual flood zones? And is there an attention put on those hospitals now for added funding to secure them or to come up with an alternate plan other than just the evacuation of the patients? But now we know that some of these hospitals are vulnerable, and now is the time to try to figure something out. Is there a study in place?

COMMISSIONER SHAH: Yes. There's actually been a lot of work done, first after Irene and Lee, and then continuing after Sandy through today in the department, and actually with the feds as well, looking at revising the flood zones, understanding which institutions are affected, understanding the plans for sheltering in place and making sure everyone understands them, working on plans for the generators so they can be, you know, plug and play across all the institutions instead of different

hookups from one institution to the next.

Different systems, something called E-finds, bracelets that when a patient needs to be evacuated from a given institution, whether it's a nursing home or a hospital, that bracelet will help you find that patient and track them in real time wherever they should go. This has been an incredible success built over just a few months, and already we're looking at other states are very interested in licensing our technology, the E-find system.

So there is a lot of work. There are after-action reports and other stuff that we can share with you and I'll have my department share. There's extensive plans for all the institutions. And not only institutions, non-institutionalized vulnerable residents, patients on oxygen, patients who are electricity-dependent. For example, insulin needs to be refrigerated, and what to do, how to identify them in real time, how to care for them in real time, when to move them or when to shelter in

place. All of that has been addressed.

ASSEMBLYMAN CUSICK: That's great. Because I know parochially in Staten Island we have two hospitals that one is in a flood zone and one is not in a flood zone. But both need help with funding to make sure that, God forbid there's another flood or another storm, that both hospitals are equally protected.

So I think that that should be part of the focus of whatever studies that we do.

COMMISSIONER SHAH: Thank you.

ASSEMBLYMAN CUSICK: Thank you. Thank you, Commissioner. Thank you, Mr. Chairman.

CHAIRMAN DeFRANCISCO: Senator Rivera.

SENATOR RIVERA: Thank you.

Good morning, Commissioner Shah. I have a few brief questions.

First of all, on the Capital Restructuring Financing Program, I wanted to see if you could briefly -- I know that you spoke about it during your testimony, but if

you could expand on it a little bit, both on the purpose and more importantly on the criteria that will be used to distribute this money.

COMMISSIONER SHAH: So the capital restructuring funds that the Governor has proposed in his budget are $1.2 billion to be expended over seven years. And we've worked in partnership with various types of institutions and societies -- Greater New York Hospital Association, HANYS, and other associations to make sure that it meets the needs.

The point of this money is, for example, when -- I'll give you one real example, if a hospital needs to transition to more outpatient care. The rooms that are set up for inpatient units are not appropriate for outpatient or ambulatory care visits. You need to reconfigure them, put in different pieces of equipment, all of that. To date, we don't have the money for it. Institutions don't have the money for it. And unfortunately the federal

government has decided that bricks and mortar or capital changes like that cannot be funded by the waiver.

That leaves a big hole in our transformation plans for the State of New York. That hole is about a billion dollars big. And that's why offering this as part of a complementary system to the waiver funding will mean that as part of the transformation plan, what the waiver can fund, the waiver will fund. When bricks and mortar are involved, this capital fund can fund. So there can be a full plan, not just let's work off of half of a plan of reducing readmissions, let's actually give the money to change our system so a hospital, a clinic, a nursing home can reconfigure to meet patients' needs in a transformed system.

SENATOR RIVERA: The criteria that is set up in the language -- I was just reading the language in the budget, and it is very -- I guess you're saying that it is flexible on purpose?

COMMISSIONER SHAH: It's meant to be as complementary as possible to the waiver. To the extent that we want the triple aim, we are looking at the State Health Innovation Plan, which is our roadmap for the next five years of New York. That is the same thing as the waiver is the same thing as -- these funds, all of them will be graded on the same metrics.

So to the extent that an application is good, it's going to be good on all levels. It's not going to be heading off in one direction with the waiver, another direction with the Health Innovation Plan and a third direction with the capital financing. They're all going to be fully aligned.

SENATOR RIVERA: I might have some follow-ups later on that.

Moving on, last year we had a long conversation both during the hearings and during the whole budget process regarding what I had termed the bucket problem. I called it the bucket problem, but this is

just the way that I referred to it. This was when public health programs in the original proposal from the Governor were supposed to be split into seven different pools, et cetera.

So I see that there is a version of it, it seems, in this budget language that relates to consolidating 36 public health awareness programs into 10 funding streams.

So I wanted to talk about how that is similar or different from last year's proposal and how exactly will it work, since it seems, at least in the language as is, that there will be no cut to the funding. But I'm still unclear as to the criteria that will be used to determine which programs would be coming back and what funding level they'd be coming back to.

COMMISSIONER SHAH: So what the Senator is referring to is in the public health budget specifically, we've tried to group together common areas -- maternal and child health -- as one bucket, where multiple buckets used to exist for maternal

programs, child health programs. Because what we've found is that many of the recipients of the funding were going across multiple buckets.

So it's the same group that would get funding from one line item and a second line item. In those kinds of areas, we've consolidated the line items, which will make for administrative simplicity to them and to us and can allow them to not silo their program in response to us.

So this is actually a win/win. It is unlike last year's buckets completely. It has no cuts in funding. It has no anticipated real changes at all other than administrative simplicity, some savings in terms of our end and on the end of the people applying for the funds. It's actually a very good thing.

SENATOR RIVERA: So if I'm not mistaken, last year we were talking about in the neighborhood of 90 programs, and this year we're talking in the neighborhood of 36. So I figure, if I'm understanding your

explanation correctly, these 36 correspond to particular agencies or entities that have programs that kind of cross over to different categories of --

COMMISSIONER SHAH: Yes. The different buckets from the past, we've consolidated them in ways that make sense for the programs themselves.

So if you're a nonprofit and you used to get funding from three different lines and you have to do three different reporting mechanisms but they're all related to maternal and child health, for example, you can apply once for the sum total of all the money you used to get, consolidate your own programs internally, do one application, still get the same amount of money as you used to under the old system, but it's better for you, it's better for the department, it's better for everyone.

SENATOR RIVERA: I might have some stuff later, but for now I'm good. Thank you, Commissioner.

COMMISSIONER SHAH: Thank you.

CHAIRMAN FARRELL: Assemblyman Lentol.

ASSEMBLYMAN LENTOL: Thank you very much, Mr. Chairman.

Good morning, Commissioner. First of all, I'm encouraged by recent developments and I'm very happy with the Governor and with you for what looks like a plus, that we're going to get the Medicaid waiver funding. I think that's -- it's definitely important to me, who comes from Brooklyn, and I'm sure to other folks in the state. And I certainly applaud the Governor for that. And I'm also pleased by the Governor's commitment to help Brooklyn hospitals.

However, I do have some questions about the funding, Medicaid waiver funding in particular as well as healthcare funding in the budget.

First of all -- and I'm sorry that I missed your presentation, but I tried to catch up by reading some of it. And you probably answered a lot of these questions

in your presentation, so forgive me if I go over them again.

One interesting plan that we looked at, at the delegation, both the Senate and the Assembly, is the Dr. Fred Hyde plan, which calls for -- that would cost the state about $1 billion to build new ambulatory care facilities in Brooklyn. That's just Brooklyn alone, that's not the whole state.

So I'm assuming that the $1.2 billion that's in the budget is not only for Brooklyn. Am I correct in that?

COMMISSIONER SHAH: You are correct.

ASSEMBLYMAN LENTOL: And I don't guess that it's necessary to spend the $1.2 billion in building all of those facilities right away, but some of it could be used in the course of a plan to build those facilities.

So I guess since you said that the waiver funding can't be used for capital projects, are we going to be able to do it? Are we going to have enough? Because we've been out front with our Medicaid Redesign

Team in trying to come up with a different proposal than hospitals. And if we don't do it quickly enough, a lot of the hospitals are going to close.

So on the one hand we have struggling hospitals that are in dire need of funding, and we have a Medicaid Redesign Team plan that will build ambulatory care facilities. By the way, I don't like that expression, because in the neighborhoods that I come from, people don't understand ambulatory care. I like emergency care. They understand that because they go to emergency rooms now. And they prefer to have something that they can hang their hat on that they understand.

That's a big question. But the more important question is, are we going to get there without allowing a huge hospital that serves indigent people in Bed-Stuy and other neighborhoods, like Interfaith, to fail before we've had the opportunity to do the right thing?

COMMISSIONER SHAH: You know, the

Governor made it clear that we can't do it alone. We need the federal government's help on this. And so we are waiting. We are having conversations every day with the federal government on moving this forward within the 30 days that -- you know, the Governor has made clear we need to get this done right away.

To the extent that -- we're optimistic. But until I get a signed letter from the federal government, I'm not saying that we have the waiver. We have had very productive conversations even as recently as Friday with folks in the White House. To the extent that we're optimistic we'll get it within 30 days, we will have the opportunity to transform many of the institutions that are teetering.

You're right, the $1.2 billion isn't enough. But there are other opportunities out there. So for example, one of the things that we've talked about is the New York State Health Innovation Plan. And in my remarks I mentioned this as well, the

SHIP. What that requires is a complete transformation of the healthcare delivery system, including advancing primary care. The payers, the private payers are on board to pony up money to help transform the system. I'm talking about the big payers.

So it's not us doing it alone. If we're all rolling in the same direction, if we're all saying this is exactly the picture of health we want for New Yorkers and to get that picture of health we need this much primary care, this much emergency care, urgent care, et cetera, et cetera, et cetera, then people know what they're rolling toward.

And so we've been very lucky to be very consistent on message. Whether you call it primary care, ambulatory care, integrated care, urgent care, emergency care, ultimately people know what we're trying to get to. It's what patients need. You know, so they don't have to wait four hours to see a doctor. So they can stay healthy and not get ill.

And I'm optimistic that between the waiver, between our SHIP plan, between all the other things we're doing with Medicaid redesign, that we will make substantial progress in real time. And we have to make real progress in real time to get these waiver dollars down. They're not just going to write a $10 billion check and say goodbye. They're going to base it on actual performance in real time on system transformation.

So that detailed plan has to be approved, and that's where we are right now, in the very weeds, so we can all see exactly where we're going.

ASSEMBLYMAN LENTOL: Another thing is that we in the Brooklyn delegation -- that I happen to be chair of, it's another hat that I wear, so I have to respond to my colleagues -- have not seen the submissions to CMS regarding the Medicaid waiver program and the applications. And I wonder if you would be able to furnish us a copy of the two years of submissions so that we could

take a look at it.

COMMISSIONER SHAH: So the issue is that we have kept on our website the broad plans. And what's happened over time, now four times in the last 18 months, is that we've kind of had to change course. you know, instead of using this construct to pay for it, we need a DSRIP construct. And so that means rewriting the plans we had against the 25 percent hospital admission reduction.

So it's essentially the same plans. And we've been very public about things that haven't been funded as a result. From our first plan to now, they're not going to fund capital. So the Governor has taken that on. They're not funding IT. You know, the few things that they aren't funding we've been explicit about.

So our goals are the same, the broad concepts are the same. Unfortunately, it is really a work in progress, a day-to-day conversation on the details of the metrics.

ASSEMBLYMAN LENTOL: Isn't this a lot

like the income tax? We send a lot of money to Washington, and that's what we did with our Medicaid redesign program. We sent a lot of money to Washington and we're getting back $10 billion after we're saving them 17 or 18 or $20 billion.

COMMISSIONER SHAH: That's exactly right. That's exactly right. We're on track to save them $17 billion, and we're asking for $10 billion back. To continue to save them even more.

ASSEMBLYMAN LENTOL: Well, okay. Let's move on.

If we receive the funding -- I'm being optimistic now. And I want to believe that we're going to receive it, whether it's $1 billion, $2 billion. Hopefully it will be $10 billion. But many people say that much of that funding should be directed towards safety net hospitals.

So I guess I don't really know -- we've heard the term bandied about a lot. I don't know exactly what it means, except what hospitals -- are we talking about the

percentage of people who use a particular hospital who are on Medicaid? Is that an important determinant? I think it is. And would the income and demographics of the surrounding area also be considered in determining whether it's a safety net hospital?

COMMISSIONER SHAH: Yeah, the vast majority of the waiver, $7.9 billion of it, is this DSRIP part of it, which is built around the construct of helping safety net hospitals. But that's writ broadly. So when you say a hospital, remember most hospitals are also the primary providers of primary care in a given community as well. They also have all the ambulatory clinics and inpatient care. A lot of it is by the hospital. So what we talk about when we talk about hospital now is not what we used to think about, which is just one tower.

And so to the extent that this waiver, when it helps our safety net, it's not really just helping hospitals, it's helping mental health facilities, it's

helping primary care, it's helping nursing homes in many instances. It's helping others who are part of that.

ASSEMBLYMAN LENTOL: Yes, I get that. I saw that in your remarks, and I'm glad to see that. But --

CHAIRMAN DeFRANCISCO: Excuse me, Joe. Joe, excuse me. With all due respect, you see that big zero, all those zeroes? They've been there for a while.

ASSEMBLYMAN LENTOL: I see it. I see it. But I'm actually speaking on behalf of all of the Brooklyn members.

CHAIRMAN DeFRANCISCO: Oh, I'm sure they'll not ask any questions. Thank you.

(Laughter.)

ASSEMBLYMAN LENTOL: And I only think there's one here, so --

CHAIRMAN FARRELL: Close.

ASSEMBLYMAN LENTOL: Thank you very much.

CHAIRMAN DeFRANCISCO: You'll get another chance, Joe.

ASSEMBLYMAN LENTOL: Do you envision

a competitive process for this funding?

COMMISSIONER SHAH: No. I mean, to the extent that it's written within the federal documents what we will give them -- the documents we give them specify this is the outcome we get, it means these are the dollars we get.

So it's not like a free-for-all, here's a $10 billion check, use it as you will, whoever is the most successful in terms of reducing readmission gets the money. It's not like that. It's prespecified.

ASSEMBLYMAN LENTOL: My last question is the billion dollars --

CHAIRMAN DeFRANCISCO: The last one was your last question.

ASSEMBLYMAN LENTOL: -- is that a maximum or a minimum amount for Brooklyn? The billion dollars that the Governor has talked about to help save Brooklyn hospitals, is that a minimum or a maximum?

COMMISSIONER SHAH: There are multiple sources of money that lead to part

of a Brooklyn solution. And it's always been about hospital transformation.

To the extent that there is money from the capital side, from that $1.2 billion; there's money from the waiver that is going to some of the safety net institutions inside; there's other monies as well, all of that combined adds up to a lot. I can't tell you how much it is today until we get our federal waiver and what that means. Because, you know, I'm hoping for $10 billion as well.

CHAIRMAN DeFRANCISCO: Thank you.

ASSEMBLYMAN LENTOL: Thank you.

CHAIRMAN DeFRANCISCO: We're joined by Senator Montgomery.

And, Joe, thank you for speaking on behalf of every legislator so that we can go on to other topics.

(Laughter.)

CHAIRMAN FARRELL: And we've been joined by Assemblyman Crouch.

ASSEMBLYMAN LENTOL: I'm sorry, Mr. Chairman, but in past meetings I'll

yield my time. I'll yield my time in future meetings.

CHAIRMAN DeFRANCISCO: Okay, great, we'll hold you to that.

And the next questioner is the Most Valuable Player of the Super Bowl, Malcolm Smith.

(Laughter.)

SENATOR SMITH: Thank you very much, Mr. Chairman.

Good morning, Commissioner. And good morning to your wife as well. It's good to see your wife here. Perhaps she might help me get in some sympathy for Southeast Queens in terms of the needs that we have.

Michele, good to see you here as well, and glad to see you here with your husband.

My first question is just one around the Health Plan Marketplace, the exchange. And you're right, you did tremendous work there. Even as Washington was having its problems, New York was speeding ahead doing a lot of enrollment. But I have just some

concerns that I have been getting from some of my constituents, in particular one around Emblem Health. And I know you in your testimony talked about 53 percent of the individuals have less expensive healthcare costs.

This particular individual, who meets the criteria for what I thought would have been a very low cost healthcare plan, has three children, she has a mortgage, and her healthcare costs went from $200 to $339. And she is suffering. Now, I know she reached out to Donna in your office and Trina in the Governor's office. But she's just one of a few. And so I guess my question is perhaps you can help me understand how that could happen.

And I'm going to give you all my questions because it moves a little faster that way as opposed to back and forth.

The second question is on the capital program, that $1.2 billion. And it talks more about rehab and transformation. And I would hope at some point we start talking

about construction of new hospitals or clinics or primary care units. Because as you know, in Queens -- and I'm excited about the waiver. I hope that while it saves money on one end it frees up resources on another. Because you know we have lost St. John's Hospital, we lost Peninsula Hospital, we lost Mary Immaculate Hospital. We now only have Jamaica Hospital, which is serving people out of trailers. And St. John's Episcopal in Rockaway is almost on the verge of falling prey to closing as well.

So from a healthcare standpoint, we don't have anything. So we need help. And I'm saying that appealing to all my colleagues who are here, as well as those in the audience, to take up Southeast Queens as a mission. Because in an area that has grown in population close to a million people, we have only one healthcare clinic on the east end -- or the west end, and one on the southern end. And both of which are doing very poorly, I should say, in terms of

healthcare. So perhaps you can help me with some of that.

COMMISSIONER SHAH: So let me get to your first question first.

You know, the individual who's seen the amount of money she spends on a monthly basis for her healthcare insurance go up, obviously Donna Frescatore is aware and will work with that individual on her particular circumstances.

But in general what's happened is people thought they had insurance, and they didn't. They didn't actually have good coverage. You know, there was entire industries out there who charged $70 a month for health insurance for their folks. And that $70 a month led to a total cost of maybe $2,000 of insurance, after which the person is on the hook. It wasn't really insurance. It was a sham.

And to the extent that what we have now is high-quality health insurance that meets very specific standards set by the feds in terms of preventive care, covering

the right kinds of things to keep you healthy in the first place, it might have gone up, but she might be getting something very different than what she thought she had.

SENATOR SMITH: Whatever she did, she cannot afford that. I mean, $339 with three children and a mortgage. And she works for a local insurance agency. Not a health insurance agency, one that provides car and auto and all that stuff.

COMMISSIONER SHAH: You know, there are going to be -- I'd love to dive deeply into a given circumstance. I can tell you that the vast majority of people for the very first time have insurance. I mean, we're getting $5 billion a year in subsidies from the feds, in terms of tax credits and other credits to help New Yorkers buy insurance. It's a very big deal.

So yes, there may be individual circumstances, and we try to minimize those and we try to see what other services they may be eligible for that could help them.

But for the vast majority of New Yorkers, for the 350,000 who have already gotten an insurance card to date on the exchange, this is a very good thing. And it's good for the hospitals, who are now getting less uncompensated care. It's good for providers. It's good for all of us.

SENATOR SMITH: So in Southeast Queens, because that's the 800-pound gorilla --

COMMISSIONER SHAH: To the extent that Southeast Queens obviously has its unique set of circumstances that are also very urgent, the North Country has its own unique set of circumstances that are very urgent.

And we are looking, and the Governor's budget suggests that regional planning is a way where each region decides what it needs based on local data, based on local culture, based on local conditions, and says this is how we need to reenvision healthcare in our system. This is what we have to work with, this is where we need to

go; State, this is how we want it. And that's where we're counting on.

And there's money to fund regional planning if --

SENATOR SMITH: And I can appreciate the analysis, the importance of it. But, you know, the paralysis of analysis where you just keep analyzing. Right now there are people in Southeast Queens that are sick, they get hurt, they have no place to go. They go to emergency rooms and they're there for three and four hours.

So a study that may go on for another year or so -- and I appreciate, you know, the regional planning. I think that concept works. But what do we do now for relief?

COMMISSIONER SHAH: Yeah, this is not a study. This is not a year. This is a -- for example, in the North Country they just started about a month ago and they're going to report out their final recommendations by March. And it's not been in isolation. Things have been happening in the North Country.

So to the extent that we're looking to jump-start the process, build off of stuff that's already happened in each region and accelerate very quickly, this is something that I think can provide real relief and, over the long term, provide a structure for continued improvement and continuous improvement of every part of this state in every region.

SENATOR SMITH: Well, I do hope you make sure that my office, as well as my colleagues in Southeast Queens, are kept abreast of it as well as being involved.

Thank you very much, Mr. Chairman.

CHAIRMAN FARRELL: Thank you very much.

We have been joined by Assemblyman Abinanti.

And we now will hear from Mr. Raia.

ASSEMBLYMAN RAIA: Thank you, Chairman.

Thank you, Commissioner. I just have two policy areas that I want to follow up with.

My office has been getting bombarded by pharmacists. And it's not often that the independent pharmacists and the chain pharmacies see eye to eye on an issue, so I guess this one is pretty important to them. And it deals with the new proposal, the Average Acquisition Cost Pharmacy Reimbursement that's in the budget.

I guess my first question is, why is the Health Department pursuing such a significant change since we I guess changed things around back in 2012, moving I guess about three-quarters of the folks out of fee-for-service Medicaid to managed care? How much money do we think we saved back in 2012 to now, and why the need for the big shift again?

COMMISSIONER SHAH: So this relates to a proposal on how much do we reimburse based on drugs. Right? There's different ways that people say I'm going to charge you 50 bucks a pill, I'm going to charge you 500 bucks a pill, and where do they base that off of, what numbers do they base that

off of.

Well, the reality is there have been a lot of different methodologies on how to pay for that pill. The reality is also that we know what's everyone paying, on average. And shouldn't New York State taxpayers get that same deal? Shouldn't we also pay what the average person is paying?

So the average acquisition cost says this is what actually -- some people are paying $5 a pill, some are paying $500. What is the average out there? We should pay the average. We shouldn't be ripped off. We shouldn't rip of taxpayers. Let's pay the average. So we're not paying the lowest, we're not paying the highest, let's pay the average. It's a standard methodology. Many other -- most other states, actually, use the average acquisition cost. You know, we've been a little behind in that sense. And unfortunately there will be some real cuts, but there will be some also gains. Because it hasn't been a rational methodology up

till now.

The average acquisition cost is fair for New York taxpayers to pay the average price for a drug that everyone else is paying, whether you're a private insurer or someone else.

ASSEMBLYMAN RAIA: Well, I appreciate that. It's my understanding that the different pharmacy associations have requested a meeting with your office, and I'm hoping that that's going to take place so maybe you can hold their hand a little.

COMMISSIONER SHAH: Absolutely. Absolutely.

ASSEMBLYMAN RAIA: Okay, thank you.

My next area is dealing with assisted living. Obviously, as New York continues to age in its population, we're seeing a greater need for assisted living facilities. And I'm just wondering if you can tell me, since the Assisted Living Reform Act was passed in 2004, how many ALR applications have been processed.

COMMISSIONER SHAH: I couldn't tell

you since 2004, but I'm sure my folks can and we can get that number back to you.

ASSEMBLYMAN RAIA: I guess one of my concerns is I believe there's been about 375 applications filed since 2005, but there's still 200 applications that remain pending. One of the concerns is I guess there's only four project managers that have literally a hundred applications sitting on their desk.

Is there anything in this upcoming budget that's going to help relieve that burden for those case managers? Because my concern is we're trying to welcome in new businesses, and certainly assisted living generates revenue for local economies.

COMMISSIONER SHAH: Yeah, absolutely. And with the whole -- we're reviewing the whole system in terms of looking at what kinds of services people need. We're taking apart our whole Certificate of Need process and saying we need to understand where our urgicenters, emergency rooms, primary care -- what is the continuum of care? How do we fill it out? And how do we make it

less burdensome and more responsive?

So that as part of that process, we will certainly look at this as well.

ASSEMBLYMAN RAIA: Because I understand you streamlined the application process, which is good because that was a nightmare in itself. But you could streamline it all you want, but if you don't have the bodies there to review the applications, it becomes problematic.

COMMISSIONER SHAH: Yeah. And at the end of the day it's about the right things for patients and about dollars. If they're stuck in a nursing home because they don't have another place to go, it will cost us more money. So we are very aggressively looking to get people what they need.

ASSEMBLYMAN RAIA: Thank you, Commissioner.

CHAIRMAN DeFRANCISCO: Senator Tkaczyk.

SENATOR TKACZYK: Thank you, Chairman.

And thank you, Commissioner Shah. I

wanted to talk about early intervention services. As you know, the state provides early intervention services through a provider network. And we're through this service reaching very young children with disabilities and providing them services to help them get ready for schools, to help them get ready for life. And these are children who are significantly disabled and need help from birth to age 3.

And last year we made a change to this service, and there were some problems with regard to it. And the problem was that the change we made in last year's budget essentially resulted in providers not getting paid timely and providers being expected to go after third-party payers and insurance companies, and they would not get paid until they received those funds.

And the problem with the providers, when it came to my attention, it seemed to be clear that there needed to be a legislative fix. And I introduced legislation last October, and I'm very

thankful that the chairs of the four committees in the Assembly came together and had a hearing all day regarding this. And I'm very thankful that the Health Committee chairs are moving legislation in both houses, and hopefully we can come up with that legislative fix.

So my question to you is, does the proposed Executive Budget contain sufficient funds to make prompt payment to providers for the services they will be providing this year, 2014-2015? And is there sufficient reappropriation money in the budget to make the still unpaid providers from last year whole?

COMMISSIONER SHAH: Thank you for your questions. You know, this was a real issue over the summer for many providers and we heard from them firsthand and in real time. As much as we could, we tried to extend lifelines to certain providers feeling the heat even more than others. And I'm proud to say as of last week we are now at 91 percent payment in terms of where we

have been historically before this whole transition occurred. We're at those rates of payment.

So we've reached -- 91 is not a hundred, and we will do better. But we have made up our losses for the last year and are where we need to be. For today, we have more to do.

There is sufficient funding in the budget -- and one of the things that people don't know is there's actually substantial relief for counties in the budget by what we've done. About 15 percent of payments from 2012 and earlier, actually, that hadn't been processed by counties, we're taking over the processing and we're advancing them very quickly. So there is actual substantial relief at many levels to the counties, to the providers, to end up with a really good system that once and for all will meet the needs of the providers and the patients they serve.

I can tell you that we've been tracking impacts on patients, on EI

recipients. And to date we haven't seen negative impacts. And we will continue to monitor that very closely and report out on it quarterly.

SENATOR TKACZYK: Well, I appreciate your comments. But to me there have been negative impacts when I know there are children in my district that are not getting services because the providers aren't getting paid and they have to stop providing those services and get another job because they have to pay their bills too.

So there was a loss of service to children at a very vulnerable age. As you know, when we help children at this age it is the best time to help them. And the fact that we changed a system and we didn't make it better, we caused problems -- I think we have to be very careful when we're changing systems that we get it right.

So I'm understanding, what you're saying is there is enough money in this proposed budget to cover all of those payments owed to providers that have not

been paid yet from last year and enough money in the budget to cover all of the providers that we expect to be needing to be out in the field in this year's budget. You're telling me that the budget is sufficient to cover both.

COMMISSIONER SHAH: Yes.

SENATOR TKACZYK: Okay. Thank you.

CHAIRMAN FARRELL: Next, Assemblyman Goodell.

ASSEMBLYMAN GOODELL: Good morning, Commissioner. Thank you very much for your comments and testimony.

I wanted to ask you a little bit about how you envision the implementation of the State Delivery System Reform Incentive Payment with the initiative of reducing inpatient hospitalization by 25 percent. And my concern is that not just Brooklyn is facing struggling times, a lot of our rural hospitals are as well.

And Mr. Lentol will appreciate I'm speaking on behalf of the Assembly Chautauqua County delegation, as the only

Assemblyman.

(Laughter.)

ASSEMBLYMAN GOODELL: But one of the challenges that I see, and I was hoping you could address, if we're reducing inpatient utilization -- and I think that's a good idea -- and working to expand outpatient services, at the same time the Certificate of Need process has been extraordinarily burdensome and expensive, particularly for our hospitals. And my hospitals are reporting that the credentialing process, even for an experienced board-certified physician, can take upwards of a year.

And so if we want to move toward outpatient services, what are we doing in this budget or overall to reduce the Certificate of Need time frame and accelerate the credentialing process so that we can actually accomplish that?

COMMISSIONER SHAH: So thank you for your questions. These are very important. You know, how do we get to 25 percent reduction in unnecessary inpatient hospital

use. There are many hospitals across the state that have upwards of 40, 50 percent inappropriate admissions. That means the patient doesn't need to be admitted to the hospital, and yet they do get there. Why? Any number of reasons. Maybe there's no other place for them to go. Maybe there's other financial issues involved.

To the extent that -- this is a big deal. Reducing it by 25 percent over five years is a very big deal. It will require an all-hands-on-deck approach. And that's what this DSRIP, this waiver, this 7.9 -- you know, this federal waiver is all about that. Because we know to achieve that vision we need to get mental health and physical health integrated. We need to build outpatient care. We need to make sure that our Certificate of Need actually is less invasive or less burdensome on primary care.

And to that extent, all of our proposals to date have actually looked to reduce the burden for outpatient care, not

set new burdens.

Certainly it's been a work in progress on the inpatient side, reducing the burdens of the Certificate of Need, and we've made real progress. And both the hospital associations will testify later today, you can ask them directly have we seen actually a net reduction or a net gain. We're going in the right direction; a lot more needs to be done.

So we're hopeful that with DSRIP waiver funds that we will continue to see the gains we need. Because we're all pointing toward the inpatient hospitalization reduction, we know what other parts of the system we need to build up that we don't put burdens on those parts as we build them up and we come to an actual unified system.

This is an incredible plan. This is shooting for the stars. But even if we don't hit the stars and we hit the moon, we'll have achieved something incredible.

ASSEMBLYMAN GOODELL: Thank you.

Could you also address why is it that the credentialing takes upwards of a year for a board-certified physician?

COMMISSIONER SHAH: Sure. It's something I have a personal interest in as well, as a doctor, and having gone through credentialing several times in New York State and seeing why do I need my diploma translated from Latin every time. The burden is incredible.

And I have convened a working group of the hospital associations saying you need to come up with a common standard. When Hurricane Sandy hits and a hospital shuts down and other hospitals are overburdened, you need to have a system so that those docs can start working in the other hospital tomorrow, not a year from now or a week from now, even.

And so we've been convening this working group. The state has been convening the hospital associations saying let's agree to common standards for credentialing. Everyone has their own unique flavor,

everyone has their own paper forms. And it is incredibly expensive, painful for physicians. It's a barrier for us to practice in this state. And we need to get to one system.

So we've been working on it. We've made some real progress. And I'm hoping that over the next three to six months -- I don't think we'll get to one form for the whole State of New York, but I think we'll get to one form for 95 to 99 percent of what a hospital needs for credentialing. And then they'll have their one-pager where they have some other questions for a doc to be receiving credentials. And that would be a state partnership with the private side so that everyone's lives are easier.

ASSEMBLYMAN GOODELL: Could you address as well the issue of getting board-certified physicians who are authorized to practice in other states authorized in New York State as well? Which is a corollary, of course, to the credentialing process.

But it's my understanding right now that an experienced physician from another state can typically get licensure authorization in our neighboring states in a matter of weeks but it takes months in New York. What's being done on that issue? Because it's particularly challenging when you're trying to recruit new physicians to come to New York State.

COMMISSIONER SHAH: So this is one of the issues that I have, is why does the State Education Department have some roles in things while I have other roles. And I would love for you guys to consider what roles should come over to the Department of Health along these lines. I'm asking for more work.

ASSEMBLYMAN GOODELL: As you can appreciate, Commissioner, the head of the education operation may have a different perspective. And so I was interested in yours.

COMMISSIONER SHAH: There's reasons why they have it. They're doing it for all

the professions, they're doing it in a unified manner. But there are nuances to the workforce issues that we face, the critical shortages we face in primary care and filling out the rest of the workforce, that make faster, more agile, responsive licensing one of the opportunities that we can work on together.

ASSEMBLYMAN GOODELL: I had one other question on a slightly different issue. And that is, as you've mentioned, we've had the rollout of the health exchange. We have multiple levels anywhere from bronze to platinum. One of our other challenges, of course, is moving people from public assistance or encouraging them to become privately employed, gainfully.

How does the Medicaid coverage right now compare to bronze, silver, gold, platinum? Or is it above platinum? And if so, how do we address that transition?

COMMISSIONER SHAH: That's a great question. And I don't think it's actually an apples-to-apples comparison, because I

can't say that it is platinum. I know that the Medicaid coverage is generous in the right ways.

And what we're tying to work on is to make it as seamless as possible so that when a recipient moves from Medicaid to a private plan on the marketplace, ideally, or back -- what we're ultimately trying to do is to get womb-to-tomb coverage. Right? Medicaid already, through Child Health Plus, we're already covering kids. What happens when they grow up? What kinds of insurance products do they go through? Most times when you get to graduate school you're again uninsured because you're over 26 and you don't have the money to pay for something.

Well, how do we make that continuum a real continuum so that folks can then get a product on the exchange that looks like some of the products they've had before? And then ultimately in the commercial space as they grow and have jobs that provide health insurance. That's the metavision, is to try to get that unified coverage with a

high-quality plan with baseline standards.

And we're already seeing that people are already starting to understand health insurance. And that actually young invincibles did sign up for health insurance on our exchange. And small businesses, while at a slow start, are starting to jump on board.

So it's been a wait-and-see kind of approach until now. But after a year or two when people see this is working, it's here to stay, and it's actually high-quality insurance at lower cost, you know what, I'm going to avail myself of this. It is working out.

ASSEMBLYMAN GOODELL: Thank you, Commissioner.

CHAIRMAN DeFRANCISCO: We've been joined by Senator Golden.

And before we go to the next questioner, can you make your answers a little more concise and to the point of the question? Because otherwise we will be here till midnight with you alone.

ASSEMBLYMAN OAKS: We have been joined by Assemblyman Crouch and Assemblyman Walter. Thanks, Senator.

CHAIRMAN DeFRANCISCO: And the next questioner is Senator Hoylman.

SENATOR HOYLMAN: Thank you, Mr. Chair.

Thank you, Dr. Shah, for being here. I'm impressed that you're sitting alone. And you've got a lot on your plate.

I wanted to compliment you first for your foresight, your diligence. And I admire you for a lot of the initiatives you've undertaken.

I wanted to ask you, though, about the status of your report on hydraulic fracturing, and in particular if you could give us an update. Who you're consulting with, whether you're going to be having any public hearings.

And I'm particularly interested in chemicals that have been found as a result of contamination. There was a *Los Angeles Times* article recently you probably are

familiar with about a study from the University of Missouri that showed that some of the chemicals can actually disrupt hormones and have led to fears of birth defects, infertility, cancer, near sites that have been sampled. And this is in Colorado. And that's in addition to the 350 instances of groundwater contamination in Colorado from more than 2,000 gas wells.

Are you familiar with that study? Can you give us a status on your health report? And will you be taking public testimony through that process?

COMMISSIONER SHAH: I was charged with a very specific set of requests from Commissioner Martens of DEC. And as part of that, what I am conducting is a health review. I'm reviewing the existing literature out there from all available sources to look at what are the potential health impacts, does our regulatory framework mitigate those risks, and if not, what else could be done to do that.

When we started, we were optimistic.

We thought that we could be finished with this review very quickly. As we've taken time to understand what's going on, there is a lot more out there. And I'm in no hurry to play with any potential risks with the health and safety of New Yorkers. So I am not in a hurry to finish my report until I am at a tipping point of the data.

What does that mean? We know that there are ongoing studies. The studies you cited, for example, go back to 1996 in terms of the kinds of patients they enrolled and the kinds of birth defects that were looked at and other things. What happened in 1996 is very different than what's going on today.

So to the extent that I'm looking at the relevance of research, how it pertains to what New York is proposing under the SGEIS framework, what is the evolving nature of the technology, all of that has to play a role. And that's why it's taken much more time and much more energy and it's been a much deeper research review than I

originally anticipated.

So I'm not in a hurry to finish this research review. To the extent that I will fulfill my charge and report back to the commissioner, to Commissioner Martens, the review when I'm ready, that is the extent of my plans.

SENATOR HOYLMAN: So are you consulting with experts in a public forum, or is this mostly a private study?

COMMISSIONER SHAH: Well, this is a highly emotionally charged area. And to the extent that we want to be objective and scientific and stick to the facts, we are continuing our work as needed, reaching out to whoever I need to reach out to.

I've in the past flown around to other experts around the country, we've engaged folks in the past individually. And we will do whatever we need to do to make sure that the review is thorough and complete when it is delivered.

SENATOR HOYLMAN: Thank you. Since I have a couple of minutes left, I'm going to

ask you about your admirable comments on ending the AIDS epidemic in New York. And thank you for those.

Could you give us an update on the department's efforts to achieve bulk pricing for HIV antiretrovirals, something that was pioneered by the Clinton Global Initiative? And I'm very happy to hear that the department is also pursuing that as well, which would, as I understand it, lower significantly the financial burden for people with HIV/AIDS and save the state money at the same time.

COMMISSIONER SHAH: So this is actually probably one of the most important initiatives from a public health standpoint of the decade, if not longer, to end the AIDS epidemic in New York State. Which is the epicenter of AIDS, which we have more cases than any other state in the country.

To be able to do that successfully and commit to it is a very big deal. Part of it is getting patients on therapy and keeping them on therapy. One of the

barriers has been the cost of the pharmaceuticals. So we are in ongoing negotiations as we speak with major pharmaceutical providers of antiretrovirals to make sure that as we ramp up patients who are getting treatment and staying on treatment, that patients can actually afford it and we can as a state afford it. We don't want another billion dollars going out to line the pockets of others.

On the other hand, there are opportunities where we can work together and really set the national model and the international model so that drug companies would be very happy to partner with us and show that this is within reach if you do it right. Let's get more patients on antiretrovirals, let's keep them on them, and let's make this just -- you know, the prevalence for the very first time to go down of HIV and AIDS.

This has been a very big part of our work in Medicaid as well for the last few weeks.

SENATOR HOYLMAN: Please let us know how we can be helpful in that regard.

COMMISSIONER SHAH: Thank you.

CHAIRMAN FARRELL: Thank you.

Assemblyman Cahill.

And we've been joined by Assemblyman Jeff Aubry.

ASSEMBLYMAN CAHILL: Hello, Commissioner. I don't expect nor do I deserve the deference that my colleague from Brooklyn got in the length of time he took to questions. So I'm going to try to do lightning-round here. I have actually six different areas I'd like to cover. I doubt very much we'll cover more than one or two of them.

But let's start with the Early Intervention Program. My experience has been, with an approximately 10-hour hearing that we held, that we could barely scratch the surface of the issue in 10 hours, I don't expect the seven minutes here to be able to go any further. But I do have some questions about the implementation.

You indicated in response to a question from someone else that you're at 91 percent payment. Can you just tell me how long it takes from service to payment to get to that 91 percent?

COMMISSIONER SHAH: As of a week ago, we're there. So to the extent that it was a moving target, there were -- there are to date folks who have not been reimbursed for services that were initially delivered in 2012. That exists.

So I don't have an average because it's been a moving average. I can just tell you that we're moving in the right direction --

ASSEMBLYMAN CAHILL: I'm going to doubt very much that the rate of payment is anything remotely close to what it was under the old system, since most providers were being paid within two or three weeks of the provision of their service. And now it's unlikely that a provider is receiving any payment in anything under 30 days, and some of them are waiting 60, 90 and, as you

pointed out, maybe two years.

Quite honestly, there was one really easy take-away from our hearing, and that's that the rollout is failing.

And I would also respectfully disagree with your assessment that services have not been diminished. You may have statistics that demonstrate that the number of providers signing on and the number of providers signing off are relatively constant, but please dig down into those statistics and you will find that the ones who are signing off are group providers and they cover 5, 10, 15, 20. And ARC went out of business. And the ones who are signing on are individual providers.

So the amount of coverage that's out there -- the network, as it were, for EI providers -- is diminishing rapidly, and it is becoming very difficult for many of the remaining providers to stay on board.

You have a fiscal agent that you've contracted with to the tune of about $45 million over the life of the contract,

plus bonuses. Has the department done any auditing of that fiscal agent to determine whether you're getting value for your dollar in terms of service?

COMMISSIONER SHAH: I'm not sure that we've had time to do the full audit that we would expect to do of that fiscal agent.

I know that we are keeping very close tabs on a monthly basis and more frequently, and we are reporting out on a quarterly basis. So to the extent that the last quarter may not reflect these last payments that occurred in the last week, the next quarter should reflect that. And we should have updated statistics.

Obviously, we need to do more. You're right.

ASSEMBLYMAN CAHILL: I would strongly suggest you do more. Several colleagues and I took the time to visit while we were in Nashville. We visited the headquarters of PCG, the much ballyhooed call center. And let me describe it to you in just very minor detail.

The signs on the door -- we went to the original offices that are listed on the registry of the building. They were four floors away from where the so-called call center was. The signs on the doors of every office were printed on a computer. They were paper signs. Coincidentally, none of the call center representatives had any pictures of their family on their desks or any personal memorabilia in the office. The only thing on the wall were standard posters promoting Nashville as a tourism destination.

The call center existed on a floor where there were -- oh, by the way, they weren't using desks, they were using portable folding tables. And they were, if my recollection serves me correctly, operating on laptops, not desktop systems.

We were told in advance that there were six people employed in the call center. Coincidentally, when we got there, all six were on the phone and unable to talk to us. But they were all there. They also

introduced us to two supervisors.

So, you know, I walked away with my colleagues -- Senator Seward, Assemblyman Barclay, Senator Breslin -- and we walked away, and I'm not going to speak for them, but we wondered if we didn't just kind of walk into something that maybe Paul Newman and Robert Redford might have done in a movie in the '70s with a little boiler-room operation that was set up just for us. It really did give us that impression.

And the result is bearing that out. Our providers have now become bill collectors. Our providers have now had to sort of double the number of hours that they're putting in just to get the payment that they used to get pretty automatically. And we're not seeing a whole lot of relief.

I would strongly urge that you take some serious steps and review that, but with the goal of making sure that our providers are able to get paid for the services that they're providing and that we don't make them into bill collectors. They're

providing a very valuable service. So if you could follow up on that, I would be very appreciative.

The next area that I wanted to cover was the Spinal Cord Research Fund. That was created back in 1998, it was defunded when the budget hit the skids in the Great Recession. And this year the Governor is proposing $2 million to be part of the fund. The fund was supposed to be $8.5 million. It comes out of the $160 million in surcharges on motor vehicle fees paid for fines.

Is there any possibility that we could see that fund increased? And if not, then how do we expect to keep pace even with what the least of the other states are doing in this area?

COMMISSIONER SHAH: Thank you for your question. So yes, we are committed to the Spinal Cord Research Funding. And I understand that one of the things that we are also doing is rolling over unspent funds from last year into this year's budget as

well. So we are actively working to manage and expand the funding to the extent possible.

ASSEMBLYMAN CAHILL: If there are unspent funds, it's surprising to me, because I can identify just three of the several dozen agencies that could use far in excess of the $8.5 million that should have been budgeted but has not been budgeted over the past several years.

You know, when it was created and when it was advocated for by people like Christopher Reeve and Sergeant Richter from the New York State Police, many of the things that were being proposed were science fiction. They were hopes, they were dreams, they were people who were desperate and hoped that they could get the services that would someday allow them to walk again, allow them to deal with neurological disorders that were impossible to deal with.

Those things are actually happening right now. We could spend $10 million or $15 million just advancing the one clinical

trial that's being carried out by NYU and Albany Medical Center. We could spend another $6 million to do some of the stem cell research that's being done in Rochester. And that's just two of the providers.

I think it's an area ripe for review. If New York is going to keep up, if we're going to do that which we can do, we ought to take a look at this fund to maybe look at beefing it up.

Thank you, Mr. Chairman.

CHAIRMAN FARRELL: Thank you.

CHAIRMAN DeFRANCISCO: Senator Young.

SENATOR YOUNG: Thank you, Mr. Chairman.

Commissioner, first of all I'd like to deliver a sincere and heartfelt thank you on behalf of the constituents in my district for your help as far as having a response to Lake Shore Hospital and the crisis that is there. And you and the Governor and your staff deserve accolades for all that you've done.

So we're hoping that we can come to a positive solution as we work through this process. But it kind of leads into a much broader topic area, and that is rural hospitals.

I believe that rural hospitals are in crisis right now. As you know, rural hospitals have a heavy Medicaid population in most cases to begin with. And as you also know, the Medicaid reimbursements are on the low side. And as a result, rural hospitals need that patient mix of private insurance and, you know, with Medicaid in order to be sustainable.

We have had issues in my district and I believe in other parts of the state where you have for-profit entities, outside entities coming in and establishing services that compete with the rural hospitals. And for example, they can cherry-pick some of the more lucrative patients and they're draining volume patients out of the hospitals and leaving them with very low reimbursements. And that has added to the

crisis, so that it's unsustainable.

But as you also know, for example, in the situation with Lake Shore, we need to have that hospital operating because for emergency room services, for example, for some people it would actually triple their time to get to the emergency room. And that's in good weather. So that you would have people maybe an hour or more, maybe two hours to be able to get emergency services. And that's not acceptable.

But I guess my question is, how can we address this issue where you have these for-profit or other entities coming in and deliberately draining our hospitals and putting them to the point where they have no other option but to go out of business?

COMMISSIONER SHAH: I think you're absolutely right, that the crisis of rural hospitals across New York State is very real. And we need to do whatever we can to think creatively about keeping access to needed services local to patients who may be in otherwise rural or distant places.

And so we're doing our best to try to think outside the box. Maybe there are things such as freestanding emergency rooms or other levels of emergency rooms that can help keep needed services in a given community when there is no sustainable way for the old model of a hospital. So there's different things we can create. And that's part of the solution to what you suggest.

And while private entities are part of the problem, private entities can also be part of the solution. They are relatively well-funded. They have money for capital. They come in with bricks and mortar to build minute clinics or other kinds of care that's provided. That care can destabilize the rest of the system or it can be complementary to the rest of the healthcare system.

Our goal is to try to make sure that those services are complementary. It's hard. It's not been easy. There's lots of need, and there isn't enough care. So how do you advance the opportunities for other

providers to come in while at the same time protecting the mission of the nonprofits? There hasn't been one answer. It's different in the western part of the state, the northern part of the state, the southern part of the state.

SENATOR YOUNG: I appreciate your response, Commissioner.

I guess what concerns me is that there seems to be an uneven playing field. So that Assemblyman Goodell spoke about the CON process that really slows down things for the hospitals. But I'm not sure what the review process is from the department as far as these for-profit entities.

And as you pointed out so well, you need to have a collaborative effort so that they're complementary and not putting one or the other out of business.

So, I guess, how do you address that with some of the for-profits? I agree that some of them could be part of the solution. But it just seems like it's unequal right now because of the review process that

exists.

COMMISSIONER SHAH: I think you may be right. I think that we are working very hard to make sure that the process is as least burdensome as possible to everyone. That's our primary goal, is to lower the bar in terms of keeping the protections in place. But the tools we have to make sure that the quality is provided are very different than the tools we had 30 years ago when this process was first developed.

So the Certificate of Need process is the basic set of tools we have to regulate what comes in and what stays out. And that's why we're looking at that very actively under the leadership of some very smart folks from around the state, to look at the rules of CON but then look at also how else can we get other folks inside.

The private marketplace is a double-edged sword. And to figure out how to manage and get what they can bring in in terms of accountability and financing and agility in terms of knowing how the

standards change, they provide high quality of care -- we've done it very successfully. Look at kidney dialysis. Look at nursing homes, where much of the market is private as well. We have not done it at all in hospitals.

So we're trying to be as creative as possible in terms of allowing the system to not collapse in and of itself, to bring in private money while at the same time protecting the public mission and public safety.

So this is a work in progress. We've had a few conversations, and I appreciate that. You've been keeping us very up-to-date on the situation because it is changing every time I look at Lake Shore.

SENATOR YOUNG: Thank you very much, Commissioner.

I wanted to follow up with some questions about the capital restructuring program and the Governor's proposed $1.2 billion over seven years. I believe it's $200 million a year for five years and

then $100 million a year for two years after that.

One of the questions I have has to do with the balance between allocation of funds with rural and suburban maybe on one side and urban on the other, and we want to make sure that people's needs are met across the state. But how will the department ensure that that balance exists?

COMMISSIONER SHAH: If you look at our history with the HEAL program, I think that's a pretty good roadmap. We were pretty balanced. Lots more money than just the $1.2 billion. And we did a decent job making sure that the needs were met across the state, equitably, in real time, with the best projects being funded.

And this was our track record of success. We have a track record of success with the HEAL program in this regard, with the Medicaid Redesign Team, with our exchange. We have a track record of success on major initiatives.

And so with the DSRIP and with the

waiver, I'm hopeful that that plus the capital money with the New York State Health Innovation Plan will be the roadmap for the transformation of the system and we will continue our track record of success in this regard as well.

SENATOR YOUNG: Thank you, Commissioner --

CHAIRMAN DeFRANCISCO: Excuse me. Before you start another question, you're going to have to go to the next round.

SENATOR YOUNG: Okay. Well, thank you, Commissioner. And you've been very good about having conversation not during hearings, so I look forward to continuing that. Thank you.

COMMISSIONER SHAH: Thank you.

CHAIRMAN DeFRANCISCO: Thank you.

CHAIRMAN FARRELL: Thank you.

We've been joined by Assemblywoman Rosenthal.

And next to question is Assemblywoman Jaffee.

ASSEMBLYWOMAN JAFFEE: Thank you,

Mr. Chairman.

Good morning, Commissioner.

I wanted to just follow up on the early intervention issue. You know, as a former special education teacher -- and I know you are very aware of how essential early intervention services are for our youth and their future. But many of our providers, as you have heard from my colleagues, have really struggled in this last year since the new system has been put into place with the fiscal administrator. They're small, they're providers, they don't have the staff to be able to really follow up and over and over again to be able to seek the financial assistance, and the financial issues really have become huge.

And they have been closing. And we are losing excellence in our community in terms of providers.

I was wondering, given -- I'm pleased that we've now responded and 91 percent have been provided funding. But considering what has happened, are you considering modifying

this system, the fiscal system, and pay the providers in the first instance? You know, really change that system and go back to a better approach so that they can be provided that financial response more immediately so that they can continue the services? Because we are losing too many of our providers.

COMMISSIONER SHAH: You're absolutely right. And we have a strong history that we can be very proud of with early intervention in the State of New York. To the extent that when this infrastructure is built, you can't unbuild it and then rebuild it overnight. We need to make sure that we do everything in our power to keep those high-quality providers in place and stable.

It's been a long road over the past year. I've spoken with staff numerous times -- sometimes it seems almost every day -- about specific issues, whether it's a eight-minute response time for the 6,000 calls or, you know -- details like that should not be something that I should be

aware of. But I do know, because it is something of primary importance. The success of EI is a success of the department. The failure of EI is a failure of the department.

What we've done over the last literally few weeks has radically transformed the state of affairs relative to the prior months. And part of it has been outside of our control, as you understand. To the extent that we've worked with the fiscal agent and with the insurance plans very closely to get the system up and running, to throw out lifelines when we can, we will continue to do that whenever we see something like that happen.

I am confident, however, that where we are today with EI is very different than perhaps even a month ago. And perhaps what we can do is have another report out to you where we can detail the differences from a month ago to where we are today. It's literally week-old information I'm talking about.

And rather than changing ships midcourse again, let's stick to the system, because I think we're there, we're almost there. And give it another -- well, let's report back to you and see what happens.

ASSEMBLYWOMAN JAFFEE: I would hope that that -- just when you look at and review what has been happening, the smaller-scale providers are the ones that are really struggling in a very significant way. So I hope that you would take a look at that as well and perhaps consider significant changes that you could offer so that they can sustain their services that they provide.

COMMISSIONER SHAH: Thank you.

ASSEMBLYWOMAN JAFFEE: I also wanted to follow up on a question regarding the hydraulic fracturing.

You indicated that you're reviewing the science and, you know, obviously looking at a thorough review. But is there a thorough review that would be more focused on a public access, a public voice, a public

process that has more transparency in terms of the public providing their responses, experts in the field, scientists, physicians, those who could provide the health input from the experts in a very public forum that would, you know, offer to those and all over this state a sense that there is that kind of review and the experts can share publicly as well as the public comment?

Is that something that, you know, is being considered? And I would suggest that it's something that should be done to provide more confidence in the community that this scientific review is something that we can understand better in a public forum.

COMMISSIONER SHAH: Thank you for your question.

You know, there are absolutely important roles for transparency. It helps the process in many ways. When it comes to certain types of science, however, there is a role for having transparency at a certain

point. There has to be an objective period during which time the science is allowed to go where it goes. For example, the complexity of some of these studies when they were done, over what period they were studied, how the measurements were taken. It's much more complex than something that a two-minute public conversation or a testimony can allow.

On the other hand, afterwards, absolutely check every single assumption, check every single fact, check how we got from where we started to where we are today, and openly look at it, dissect it.

The issue is when do you do that. And right now it's changing so quickly, there's so many studies coming out, that I'm not prepared yet to start that conversation today in a forum that will just add to confusion and will distract from the work that is going on.

ASSEMBLYWOMAN JAFFEE: But moving forward, there will be a public forum, public discussion?

COMMISSIONER SHAH: To the extent I've been asked to deliver a report to Commissioner Martens, I will deliver my report to Commissioner Martens and then he can choose to do whatever he likes with it.

ASSEMBLYWOMAN JAFFEE: I also just want to close by thanking you for your recognizing the shortages in primary care in our communities. I think focusing on primary care is essential. It's preventive and it really helps so many to be able to really be healthy as children, as adults.

And, you know, as an educator I've seen too many in our community, as you noted earlier, who do not have the healthcare and then they wind up in the emergency room, and not only is it a cost to all of us, it's also a cost to them in terms of their lives and quality of life. So I think we need to continue to focus on more access for primary care, and I appreciate that effort.

Thank you, Commissioner.

COMMISSIONER SHAH: Thank you.

CHAIRMAN DeFRANCISCO: Senator

Montgomery.

SENATOR MONTGOMERY: Thank you, Mr. Chairman.

Good morning, Commissioner.

As you have mentioned and you know, that we have extreme issues in Brooklyn, Kings County, as it relates to healthcare issues generally but also several of the hospitals in trouble. And in your presentation to us you talk about the Triple Aim and that our healthcare system relies too heavily on inpatient care, emergency room services and nursing home care, and not primary care and other community-based alternatives.

So my question, I will combine two issues into one. It's regarding the waiver money that we are all hopeful will come. And hopefully it will be available to us in a timely enough fashion so that we can actually help to stem the tide of failure. My question is, what will be the formula or the process of distributing the waiver funds? And how, in fact, will that be part

of a recovery for the Brooklyn situation? That's one part.

And we know that we have a number of FQHCs that provide healthcare, which is really a very big part of your Triple Aim. But I'm not seeing in your presentation or necessarily in the budget itself a focus on those organizations that tend to be sort of left out of the equation. And they're looking to become more a major part, a central part of the delivery of the healthcare system, particularly as it relates to primary care and community-based care.

So I would like to see what the waiver funding is going to do for those two areas.

COMMISSIONER SHAH: So one of the things that we have in our waiver fundings is half a billion dollars for Health Homes. Now, what are Health Homes? They're constructs of providers, whether it's an FQHC plus a hospital plus an AIDS outreach, groups of providers who come together to

work on those chronic patients, those patients who are 5 percent of the population responsible for 50 percent of the cost. Right? Those are the expensive patients with more than one problem. And those are the folks who are bouncing around the system not getting the preventive care they need.

To a large extent, how are you going to reduce their hospitalizations is by integrating them into high-quality primary care, often delivered by Federally Qualified Health Centers.

So that is something that we've had up and running now, and it's been working very well. And we seek a major expansion of that as part of the waiver. A hospital is only going to keep the patient out of the hospital, reach that 25 percent goal, if they meaningfully partner with primary care and with mental health services and with other community-based services.

So while it's a waiver for the hospitals, it's really not about the hospitals where you're going to see all

those big gains. A lot of those big gains are only going to occur if hospitals partner with everyone in the community, including FQHCs.

SENATOR MONTGOMERY: And so is that part of the formula for distribution of the waiver funding? Or how will you in fact enforce this plan?

COMMISSIONER SHAH: So to the extent that they show credible plans that show how they're going to reach that 25 percent over five years, only then will the money flow. All of those plans will include successful components that we know that work, including strong partnerships, bidirectional partnerships with community providers, FQHCs and others.

So yes, it will be a part of it. It will be because they can only achieve that 25 percent reduction if they meaningfully partner.

SENATOR MONTGOMERY: Okay, that's good.

I think I have a half a minute that I

want to just ask on another issue, related but not exactly the same, of the school-based health clinics. It is my understanding that as of October they will no longer be carved out. And so that means that they will, for the most part, not be covered because they won't be able to survive under the new system of managed care.

So can you give me some idea as to what your plans are to make sure that we don't lose what we already have and that we move toward also -- they're not FQHCs, but they play a very significant role in providing healthcare for young people.

COMMISSIONER SHAH: And actually it's the other way around. The school-based health clinics have done a fantastic job showing how good they are at keeping asthmatic kids out of the hospital emergency room and elsewhere. So as we move to managed care, what we're doing is giving them a more stable, long-term, sustainable funding source rather than the one-offs in

the budgets or the exclusion.

To the extent that I think of this as a real opportunity, what we have been doing is having very regular meetings with all the stakeholders, with all the folks at school-based clinics. How do you live in a managed-care world? What do you need to do between now and October to get there? How will you continue to sell your story? How will you partner under the waiver? All of these conversations are happening regularly between Medicaid and other parts of the department with school-based clinics with a working group, so that they can successfully make that transition. And I think they're going to do very well.

SENATOR MONTGOMERY: Well, I look forward to working with you as well to make sure that they don't fall through the cracks in this transition period. So thank you for your support of that.

COMMISSIONER SHAH: Thank you, Senator.

CHAIRMAN FARRELL: Thank you.

Assemblyman Oaks.

ASSEMBLYMAN OAKS: Thank you, Commissioner.

I just want to build a bit on Chairman Gottfried's discussion of the prior authorization on the off-label drugs. Can you tell me what drug classes there might be that are being prescribed for off-label use, and then maybe some specific examples of some of those drugs?

COMMISSIONER SHAH: So I can tell you there is an epidemic of our children, of our youth being prescribed very active medications that affect brains over time. Expensive medications, antipsychotics. They have not been studied in children. There is an assumption that they will help with behavioral issues in the classroom and as a result kids will be able to participate in normal classrooms. There has been an epidemic of sorts in this regard.

To the extent that this is largely, almost exclusively off-label and of real concern to me, this is one example where we

might be able to ramp that back with such a policy.

ASSEMBLYMAN OAKS: All right. If you have an opportunity, as a follow-up, you know, I'd be interested in seeing -- you know, again, you gave that class -- of looking at others and/or some of the specifics that we are concerned about as a state.

Also I wanted to bring up the General Public Health Work program and its expansion to include prenatal care. Will all of the women who are receiving the prenatal care be required to enroll in a health insurance program?

COMMISSIONER SHAH: No. I think the goal of that is to really try to get insurers to pay when they should be paying and, on the other hand, for women who don't have access through any other means to still have that safety net.

So the goal is that let's get the right folks with the right pockets paying, not to really cut services but to cut the

costs to the state while still retaining a strong safety net so no one is left behind.

An extension of that is trying to extend the Nurse-Family Partnership, for example. We're trying to get first-time Medicaid moms to actually have a nurse visit them in the home every month through pregnancy and for two years after. That's an example of a service that we're extending and expanding on so that the safety net is stronger, because there's a strong evidence base that it works.

ASSEMBLYMAN OAKS: Will counties be negatively impacted if they don't make a good-faith effort to assist with enrolling the moms?

COMMISSIONER SHAH: I'm not sure I understand the question.

ASSEMBLYMAN OAKS: Well, there is some wording, as I understand it, of making a good-faith effort of enrollment. And so it was just kind of looking at now they will be eligible if the counties don't come through, you know?

COMMISSIONER SHAH: Yeah. I mean, obviously this is in everyone's best interest. It's in the mom's best interest to be in a high-quality program, not just one service. It's in the county's best interest to get out of the business of -- which they've been doing for a while, but they're getting more and more out of it as insurance companies and others are picking up, and focusing more on their public health and other areas.

So there will be a transition period. I can assure you that we will watch it very carefully and make sure that any transition issues that occur will be addressed in real time.

ASSEMBLYMAN OAKS: Thank you, Commissioner.

CHAIRMAN FARRELL: Thank you.

CHAIRMAN DeFRANCISCO: Senator Hassell-Thompson.

SENATOR HASSELL-THOMPSON: Thank you, Mr. Chairman. It is afternoon. Good afternoon, Commissioner.

I have a series of quick questions. One, I just wanted clarification. Earlier you said that regions know what their health needs are, and I agree with that. But then you went on to talk about a regional concept for healthcare. And I was hoping that you were not paralleling that with the regional economic development plans which makes it competitive. You did not mean that?

COMMISSIONER SHAH: No.

SENATOR HASSELL-THOMPSON: Oh, great. Okay. Then I can move on to my next question.

I, like you, am very pleased to hear that there are only two new cases of maternal-child transmission of HIV and AIDS. But how does that stack up against HIV and AIDS in the African-American community when in 12-to-22-year-olds new cases are being found every day?

COMMISSIONER SHAH: We have not won the battle. What we are suggesting is that we can, by 2020, commit to the prevalence of HIV and AIDS in New York State going down

for the first time in history.

What I'm suggesting is we know we've won the battle for maternal to child transmission for IV drug abusers, but there are men who have sex with men in African-American and other populations where we need much more efforts.

What we're proposing is a plan that gets to that. For example, there are people who have HIV or AIDS who are in the system but then drop out of the system. How do we engage them back in the system? Well, maybe they're getting a blood test for something else or maybe they're getting care somewhere else. Let's use that to get them back into care.

What we are proposing is a full plan that looks at African-Americans in particular, but all the vulnerable populations where we haven't made enough gains, and working with the community to identify those patients and to get them into care.

There are a lot of patients who don't

know their diagnosis. There are tens of thousands of New Yorkers today living with HIV who don't know they have HIV. Let's get them diagnosed. All of that is part of the plan. And a large part of that burden falls on underserved minority communities. That's where our focus will be.

SENATOR HASSELL-THOMPSON: Well, what is the plan for the 12-to-22-year-old? You know, the plan that you're talking about sounds good for that particular population. But what are your educational and awareness plans for the 12-year-old?

COMMISSIONER SHAH: So to the extent that we're working with the community partners in tandem and they're helping drive the agenda. We're working with them to say this is how we identify these patients, this is how we get them into care, this is how we prevent it in the first place among the 12-to-22-year-olds.

I'm not relying on just the AIDS Institute to solve all the problems. Our community partners, who have had a long

history of very successful advocacy on behalf of these populations, are going to be fundamental to the success.

SENATOR HASSELL-THOMPSON: And my last question, the federal guidelines for the standards for pre-K includes healthcare services. How does your budget reflect this increase in services to this new population or increased population as the Governor rolls out his pre-K plan?

COMMISSIONER SHAH: So again, that's a great question, where we're looking from the whole continuum, how do we first catch kids and take care of them throughout the continuum of their lives to keep them healthy.

And we spoke earlier about school-based clinics. That's an example where school-based clinics, as they expand, as they have a stable funding source through managed care, they will have opportunities to think creatively outside of the box to actually engage new populations. We know that taking care of a kid and keeping him or

her healthy is much better than paying for the diabetes or the knee replacement or the heart transplant after the fact.

So what we're doing is we're actually for the first time building that system of healthcare so we can make the right investments at the earliest stage possible.

SENATOR HASSELL-THOMPSON: But currently, as I understand it -- and correct me if I'm wrong -- school-based clinics have been targeted towards junior-high and high-school students. You know, pre-Ks are a very different kettle of fish, and we haven't done this in a universal sense.

So what is the plan for us, how would school-based clinics affect this particular population?

COMMISSIONER SHAH: I'm suggesting school-based clinics as one potential alternative. It is not yet real. It is an opportunity out there. To date, what we do with funding through Child Health Plus and Early Intervention and other programs already have points of contact with the

pre-K population. To the extent that pediatricians need to be paid more, that the patient-centered Medical Home Model needs to be strengthened, all of these kinds of things can help pre-K kids outside the school.

There may be opportunities, as we see school-based services expand, to also think inside the school, because that's where you can reach them, that's where they spend a lot of their time, and that's where you can start to influence the family, not just the child.

SENATOR HASSELL-THOMPSON: You're speaking conceptually.

COMMISSIONER SHAH: That's right. Because it is still a concept.

SENATOR HASSELL-THOMPSON: But you're speaking conceptually. My question was budgetarily. Where is it in the budget?

You know, because while you're talking about pre-K as it currently exists, the Governor and everybody is talking about expanding on that number significantly. And

I'm not clear that your budget reflects that. That's my question. I understand the concept, but I want to see it in the budget.

COMMISSIONER SHAH: Okay.

CHAIRMAN FARRELL: Thank you.

Assemblywoman Millman.

ASSEMBLYWOMAN MILLMAN: Thank you. I think I still can get in "good morning." Thank you, Mr. Chairman. Good morning, Commissioner. Yes, I know, I will have to speak fast so I get it all in in the morning session.

One question that I still don't understand is, as you know, I'm the Assemblymember who represents one of these very distressed hospitals in Brooklyn, and very much looking forward to get our share of the Medicaid waiver. But I don't understand why I've been told several times that when we are successful, and I certainly hope that we'll be successful as soon as you alluded to earlier, why this Medicaid refund for us -- and it is a refund in a lot of ways -- will not address the needs at

Long Island College Hospital. Could you expand on that?

COMMISSIONER SHAH: Sure. So the Long Island College Hospital is a different situation than Interfaith, specifically. To the extent that we're working with SUNY and working with SUNY on their RFP and helping them along in terms of their thinking, SUNY and the local courts are really in charge there. We are here to provide any support that's needed.

But again, the purposes of the dollars from the waiver have to meet very specific needs. They have to show how we are going to reduce admissions by 25 percent, those ambulatory sensitive admissions and unneeded admissions. Only then will any institution or institutions get such dollars. Right? That kind of transformation can occur with Interfaith.

LICH is a different story. LICH is already -- you know, they're on their own right now, with SUNY and us helping as much as we can, but that's a process that they

are controlling and that is moving forward independent of the waiver process.

ASSEMBLYWOMAN MILLMAN: And so we're now that process with the new and improved, if you will -- and I don't think it's new or improved -- but RFP process, which is due the end of today with the -- SUNY has allowed the firms, if you will, to reapply. And if one of those applications comes through as the most successful one and addresses some of the concerns that you expressed before, then could the waiver then be used if one of these were to be successful?

COMMISSIONER SHAH: I don't know. I honestly don't know.

ASSEMBLYWOMAN MILLMAN: All right, thank you. Let me ask you about something totally different.

As chair of the Aging Committee, we've spent a lot of time talking about the crucial element in our aging population, and that's the AIDS -- well, AIDS is also something that's cropped up, but I want to

talk about Alzheimer's. And it is now close to $2 million that's sitting somewhere, and it comes about as people who have done a check-off on their income tax. And it's supposed to go for AIDS, for Alzheimer's concerns, and yet none of that money has gotten out the door.

And I think it's $1.8 million now, that was the last number that I got. So it's close to $2 million. So what is the department doing to see that that money gets to the organizations that are doing such fine work in all parts of our state?

COMMISSIONER SHAH: Yes, thank you for that question. And it is an important epidemic that we need to address as well with the aging population.

We have actually, over the last month, started to come up with very specific plans on how to move that money and, most meaningfully, work on early diagnosis and getting folks into treatment as quickly as possible with those monies. And at some point in the near future I'm sure we'll be

ready to share those plans with you, and we will reach out to you directly.

ASSEMBLYWOMAN MILLMAN: And then before I leave this topic, and that's the last question that I have for you, what caused the delay? Because people have been checking that off for some time now. This is not just something new that happened. I mean, for that many people to put whatever small amount it is to come out of their income tax refund, to collect that, what happened? Why was there such a delay?

COMMISSIONER SHAH: So there are delays, you know, across the board because sometimes the nature of the law may not allow for expeditious spending of the money.

I'll give you a real example. With the prostate cancer check-off box, it was only one organization in California that was specifically named that could get the money. We need a change of the law. And in the Governor's Executive Budget we have proposed that change in the law so that we can expend those funds.

To the extent that there are different issues where money has been unspent, we are trying to address actually about six different areas in this Executive Budget that Governor Cuomo has proposed.

ASSEMBLYWOMAN MILLMAN: So I can expect from you at the time that we do something in terms of which organizations will be the beneficiaries of this money, I'll hear something from you on that front?

COMMISSIONER SHAH: You will hear a full update on where we are and what our plans are shortly.

ASSEMBLYWOMAN MILLMAN: Thank you very much.

CHAIRMAN DeFRANCISCO: Senator Golden.

SENATOR GOLDEN: Thank you, Mr. Chairman.

Thank you, Commissioner, for your testimony this morning. We're looking forward to working with you and the Governor to get this Medicaid waiver. It's important that we get it, the federal waiver, so that

we can help those 237 distressed hospitals across this state. So we're looking forward to working with you to get that accomplished.

I understand we had $17 billion in savings for the federal government, which I presume was a $17 billion in savings to ourselves as well, so it's a $34 billion savings. Could you get a breakdown for us, for myself, so that I can have a better argument as I present these arguments to the federal government? We have some press releases going on, and we'd like to have how we were able to save that $34 billion for the state. And if the chairs of the committees could get them as well.

COMMISSIONER SHAH: So the question related to how do we save $34 billion. We're on track to save $34 billion. To be honest, we've saved $4.6 billion in the first year alone, and we're on track to save $34 billion combined state and federal.

A lot of large programs led to these savings. One has been the commitment to the

global cap. As we committed to a global cap, it's now a 3.8 percent rise in Medicaid this year. What that has done is that has changed provider behavior. They know that we're looking at them and that we're reporting out on a monthly basis, to the dollar, how much each sector is spending, how much is going toward nursing homes, how much is going toward managed care.

SENATOR GOLDEN: Could I get a one-page memo on that?

COMMISSIONER SHAH: Would you like a report on that?

SENATOR GOLDEN: Yes, please.

COMMISSIONER SHAH: Yes, we'll send you the monthly reports going back from the beginning of the program.

SENATOR GOLDEN: Thank you.

There was money distributed, $170 -- $150 -- $160 million out of HEAL money. I believe there was an announcement last week, about $56 million or $57 million was distributed. A large chunk of that went to the Brooklyn hospitals.

I understand that Lutheran Medical was at that table in discussions. I understand that they're working on a margin of 0.26 profit, which is not exactly a big profit margin. But they obviously were not chosen at the end of the process. So they were looking for $9 million over a three-year period to combine their billing systems. And we know that the waiver does not take into consideration IT or capital.

Is there going to be additional dollars that are going to be -- is any additional HEAL money going to be going out?

COMMISSIONER SHAH: My impression is that the waiver and the capital monies are the only sources to date.

But to the extent that when you pay for something, like bricks and mortar, that they have money for, they can repurpose their own money to use it on something else. And what we're looking for is the strongest applications that take all of that into account so that a system stays strong and grows. So there is no other money, there

are no other pots of money beyond the waiver and the Governor's $1.2 billion in capital.

SENATOR GOLDEN: Well, they're in desperate need of those dollars. So if there's somebody from your office I can sit with in the near future to figure out how we're going to keep them alive. It's important that that hospital does not become one of those hospitals in the red very shortly. Brooklyn has enough issues going on. We need to keep those that are in the black in the black. And I think they need that funding.

The tobacco. We came to the 11th hour in getting a bill passed that would put more investigators on the streets going after the illegal cigarettes and tobacco on the streets costing this state probably close to a billion dollars. We do know that if we were out there with these investigators and the price of cigarettes were what they should be, cigarettes would go down and obviously healthcare would become better here in the State of New York.

If you could chime in with the Governor's office and the powers that be that we need to get this closed as soon as possible so that we can get more investigators on the street -- every other store in Brooklyn and Queens and the Bronx is selling illegal cigarettes, every other store, unstamped, from Virginia, from Texas, from China. They're from all over.

It is a shame. It is the new drug across this state. And I go to these stores, it's pretty embarrassing. So if you could please chime in, we need your help in getting that bill done and more investigators on the street.

And I understand that the hospitals, our research hospitals are of a concern that we're losing some of our researchers and we're going to lose more of our researchers and our star scientists. I believe Texas has put in $3 billion for cancer research, California put in multi-billions of dollars for stem cell, Connecticut has put in a billion dollars for biomed and biotech.

Do you have the same fears, Doctor?

COMMISSIONER SHAH: We have been very proactive about addressing the loss of scientists in our academic medical centers with the total reenvisioning of our ECRIP program. And that's on the tune of I think about $18 million. Obviously the stem cell funding. And becoming more competitive for federal funds.

So as a scientist and as a researcher, absolutely I'm in tune with this and I'm looking at any and all advantages New York researchers can get as they compete for federal and other funds.

We have been actually quite successful in stem cell funding, leading to more stem cell researchers in New York relative to other states. And I'm hoping that with the ECRIP program we can continue on that tradition and extend it to other areas.

SENATOR GOLDEN: We have a bill that's coming out that deals with biotech, biomed and incubators and incentivizes them

to operate here in the city and state of New York and to give more opportunities for these researchers and star scientists to stay here. Hopefully you'll get a look at that and hopefully you can support that bill. That bill will be coming out shortly.

The I-STOP that we were so good at doing and limiting the prescription pills -- and I'm going to tell you, in my community, Oxycontin seems to be going down and prescription drugs seem to be going down, but heroin seems to be the new drug of choice. Not only in the areas of Brooklyn, but in Staten Island and Long Island it seems to be rampant. Any comment on that?

COMMISSIONER SHAH: Absolutely. We know that and we're watching very closely and working with law enforcement partners to make sure that as we enforce with I-STOP we also provide a lifeline with adequate treatment and programs to try to get folks who don't have access anymore to get on the off-ramp rather than switch to illegal drugs.

SENATOR GOLDEN: Are you seeing the same results?

COMMISSIONER SHAH: Anecdotally. I don't have numbers to back that up.

SENATOR GOLDEN: Thank you.

Last question, I'm sure Senator Hannon may have dealt with this already, and if he did, just ignore it and we'll move on. The in-network and out of network. We dealt with the out-of-network situation when it came to emergency care. Everybody is in-network if it's an emergency situation. If it's not an emergency situation, it's a planned procedure such as a transplant, and you want to go into the City of New York to have that done (a) you have problems because the hospitals there have a limited number of plans. Some of them have no plans. And out of network is definitely a situation for the residents in the areas that I represent and I'm sure for many of my colleagues.

Are we going to require some form of out-of-network policy for these plans?

COMMISSIONER SHAH: It's premature to

discuss our plans. I can just tell you that we are monitoring network adequacy continuously. And as any issues crop up, we will make appropriate changes.

SENATOR GOLDEN: Because it is definitely onerous on an individual to make sure if you're having a transplant and you're going to have 30, 40 people in and out of your room over the course of three to four weeks, to make sure that every individual is in-network. That's onerous to the individual that's having those procedures done and can be quite costly. So you can understand the importance of that one.

Thank you very much, Commissioner.

COMMISSIONER SHAH: Thank you.

CHAIRMAN FARRELL: Thank you.

Assemblyman Abinanti.

ASSEMBLYMAN ABINANTI: Thank you, Mr. Chairman.

Thank you, Doctor.

I'd like to follow up on the last field that we were just talking about.

There are reports that the health plans that were obtained through the Health Marketplace have not reached an agreement with the Westchester County Medical Center. And as of now, none of the people who have those plans can access the Westchester County Medical Center, which is the major trauma center north of New York City and, as I understand it, the only real trauma center between New York City and Albany.

What is your department doing to resolve this problem?

COMMISSIONER SHAH: So we are absolutely monitoring that to the extent that in an emergency situation, for example, trauma, a car accident --

ASSEMBLYMAN ABINANTI: Doctor, thank you. I don't have much time. I understand the theory behind it, and I appreciate your monitoring it. I'd like to know what your department is doing. Are you intervening? Are you working with the medical center and the -- what are you doing?

COMMISSIONER SHAH: For trauma

services in an emergency situation, they would be covered.

ASSEMBLYMAN ABINANTI: That's not my understanding today. How did you come to that conclusion?

COMMISSIONER SHAH: We'll check. I'll get back to you. But that's --

ASSEMBLYMAN ABINANTI: Thank you very much. Next I'd like to move on to -- you were talking about a database program. Is this going to be tied into the P20 or whatever that program is the State Education Department is using?

COMMISSIONER SHAH: I'm not sure what database program you're talking about.

ASSEMBLYMAN ABINANTI: P12, I don't know. There's some large database that the Education Department is trying to put together to monitor and track children from the age of 3 through adulthood. Is this going to be part of that?

COMMISSIONER SHAH: I have no plans to work with -- I am not aware of that program, and I have not had discussions with

State Education about combining any databases with their P20.

ASSEMBLYMAN ABINANTI: Now, who is going to hold all of this data that you're proposing for a statewide system?

COMMISSIONER SHAH: I assume you're talking about the Statewide Health Information Network-New York, the SHIN-NY?

ASSEMBLYMAN ABINANTI: Yes.

COMMISSIONER SHAH: So that is actually something that today all the regions already have. There are 10 regions, RHIOs, Regional Health Information Organizations.

ASSEMBLYMAN ABINANTI: And who holds the data today?

COMMISSIONER SHAH: The regions.

ASSEMBLYMAN ABINANTI: Who is the region?

COMMISSIONER SHAH: So for example, here, or let's say in Manhattan, right there the hospitals have set up a system where they connect to each other and they have servers where they store data in a secure

format so that when a patient gets admitted to one hospital versus another --

ASSEMBLYMAN ABINANTI: Right. That's the hospitals with their own private databases and linking them together. They form their own little Internet.

COMMISSIONER SHAH: Essentially.

ASSEMBLYMAN ABINANTI: When we go on a statewide system, are you talking about giving this to a private company?

COMMISSIONER SHAH: No.

ASSEMBLYMAN ABINANTI: So who is going to be in charge of the database?

COMMISSIONER SHAH: It's a federated system where the data is local, but it's connected. We're building the pipes. What we're suggesting is building the pipes --

ASSEMBLYMAN ABINANTI: But this will be state employees that will be managing this?

COMMISSIONER SHAH: There will be state oversight of --

ASSEMBLYMAN ABINANTI: That's different than state employees.

COMMISSIONER SHAH: That's correct.

ASSEMBLYMAN ABINANTI: Are we going to have outside contractors doing this?

COMMISSIONER SHAH: We will have outside contractors doing it who are currently doing it today. The --

ASSEMBLYMAN ABINANTI: Who's doing background checks on these outside contractors, and who's making sure that this data is secure?

COMMISSIONER SHAH: Absolutely, that is my primary concern, is that the data is secure.

ASSEMBLYMAN ABINANTI: My question was who is doing it, not is it your concern.

COMMISSIONER SHAH: And who is doing that today? For example, KPMG does audits of all of them.

ASSEMBLYMAN ABINANTI: Excuse me?

COMMISSIONER SHAH: KPMG is one of the auditors that audits these to maintain the security of these --

ASSEMBLYMAN ABINANTI: Well, Target thought it was secure also.

I'm concerned about making sure that this data remains secure, and I wanted to know who is in charge of this. Who are you planning to give this contract to who is going to hold the medical/clinical patient data of every person in the state?

COMMISSIONER SHAH: No one will hold all that data. What we're creating is a network which will allow connections across the system, so when you get in a car accident in Buffalo, they can pull up your medical records from Brooklyn.

That kind of thing already exists at regional levels. What we're doing is we're building the pipes to connect it at a statewide level. Anytime anyone accesses any of that data, there's a full audited trail of who accessed it and when, why, where.

ASSEMBLYMAN ABINANTI: Who does the audit?

COMMISSIONER SHAH: KPMG.

ASSEMBLYMAN ABINANTI: Is that available to us to look at?

COMMISSIONER SHAH: I'm not aware that it is available to the public or anyone right now. I know that they are one of the contractors who adequately provides oversight to federal standards of HIPAA to make sure that the data is secure and private. That is my primary concern, is the security and privacy of that data.

ASSEMBLYMAN ABINANTI: Doctor, you were talking about the Medicaid Redesign Team, and we were talking about managed care for people with developmental disabilities. How is that going?

COMMISSIONER SHAH: We are going slowly and we are making sure that all patients will be ultimately cared for in systems. The DD issue is one of those things that we're working on over time, and we'll delay it or accelerate it as needed to make sure that patients get what they need.

ASSEMBLYMAN ABINANTI: I'm glad to hear you're not rushing into it without following it carefully.

Do we have a survey of how many

psychiatrists and how many mental health professionals actually belong to networks today?

COMMISSIONER SHAH: Belong to whom?

ASSEMBLYMAN ABINANTI: Belong to the networks that you're hoping to move these into.

COMMISSIONER SHAH: I don't have that data.

ASSEMBLYMAN ABINANTI: Has the Health Department done that data?

COMMISSIONER SHAH: I'm not aware. I would assume that if you're talking about the developmentally disabled that you're talking about OPWDD, and perhaps that commissioner might have that information for you.

ASSEMBLYMAN ABINANTI: Well, isn't it your department that's moving forward on the Medicaid redesign?

COMMISSIONER SHAH: Absolutely. And we work with them on that level of data.

ASSEMBLYMAN ABINANTI: Because I'm concerned. I'm hearing from mental health

professionals that most of them do not belong to networks, that many of them are not physicians, and so they're going to be losing their clients, in effect.

But the impact is on the clients. They'll find another way to make a living, but it's on the clients who are now not going to be able to use their current mental health professionals because the mental health professionals are not part of the networks that are being used for the Medicaid redesign.

COMMISSIONER SHAH: To the extent that we want to minimize any and all disruptions, especially when it comes to mental health services, that will be closely watched and tracked. We have only seen --

ASSEMBLYMAN ABINANTI: Watched and tracked. But you haven't done any surveys yet to see how many mental health professionals match up with the networks you're planning to use?

COMMISSIONER SHAH: No, I said I'm not aware of those. I said maybe the

commissioner of OPWDD is aware, or we can find out that information and get back to you.

ASSEMBLYMAN ABINANTI: Lastly, on the early intervention, I share my colleagues' concern because I believe that what you're espousing here is good theory but is in fact very different from what's happening on the street.

I have a stack of letters right in front of me now that came in January 15th, January 20th, indicating that while the percentages of claims being paid has in fact increased, the amount of money outstanding has not. And it's the amount of money that is out there that is a major burden on the providers.

And that in fact now a large number of these professionals -- not the providers, but the professionals who provide the services, like the behavioral therapists, have left the field. There is a limited number of them, they're in great demand, they can go do something else in their

fields. They don't have to do early intervention. And that now we have a major backlog of parents trying to get services for their kids -- even in a place like Westchester County, where there's lots of providers.

And as you understand, if we have just a month's delay for a child who's a few months old, that's a major, major problem.

CHAIRMAN FARRELL: Thank you.

CHAIRMAN DeFRANCISCO: Senator Gipson.

SENATOR GIPSON: Thank you for being here today.

I'm sure that you recall that recently the CDC released some numbers stating that they had discovered that there were 10 times more cases of tick-borne illness across the country than we had previously thought. And based on the research that's been provided by the Health Department, they have been steadily decreasing funding in terms of research related to trying to find preventative ways

to deal with our rising health crisis of tick-borne illness here in New York State. In fact, in the last six years the funding has decreased over 50 percent.

Could you explain why that decrease in funding is occurring while the cases of tick-borne illness are rising in New York State?

COMMISSIONER SHAH: At the federal level?

SENATOR GIPSON: No, at the state level.

COMMISSIONER SHAH: So to the extent that we are recipients of many of the federal grants --

SENATOR GIPSON: Right, but the state -- of the state itself, within what the state can control, obviously, within our budget, there has been a steady decrease in the amount of funding that we're devoting internally to the Tick Disease Institute within your Health Department.

COMMISSIONER SHAH: Sure. Thank you for your question.

So to the extent that absolutely tick-borne illnesses is something that we take very seriously as a public health issue, and we are monitoring it all the time. We are the recipients of multiple federal grants now to actually conduct primary research on tick-borne illnesses --

SENATOR GIPSON: Could I just interrupt to ask how that grant funding will be distributed? Because in the current proposed Executive Budget there seems to be sort of a bundling of all money related to infectious disease. It seems like what's going to be happening is that tick-borne illness, HIV/AIDS, hepatitis, STDs, mumps, rabies, rubella, that that's all going to be put into a competitive grant pool.

Are we going to have infectious disease groups sort of compete like an NCAA basketball tournament where there's sort of bracketed competition and we have to pit these groups against each other? That doesn't seem to be an effective way to deal with infectious disease.

COMMISSIONER SHAH: No, actually it's the other way around. What we're doing is we're making their lives easier. It was the same group that was getting money from multiple different buckets; now they have one consolidated bucket. And if you'll notice, the funding is the same.

So our intent with this bucketing is to actually make the lives of the recipients easier, make the lives of the department easier to do one big grant to a given organization instead of three separate across three separate buckets as in the past. And so this is actually a good thing in this year's budget --

SENATOR GIPSON: But does that mean that every infectious disease organization within the Health Department will be receiving funding? In other words, for instance with the tick-borne illness issue, the Tick Disease Institute within your commission, if it could not meet whatever qualifications that are needed to receive that competitive grant funding, would it

just not receive any funding?

And the same thing with HIV/AIDS. Do they have to show some kind of proof to be eligible for this money? Will all of these groups get the funding they need, or is it going to be competitive?

COMMISSIONER SHAH: It's the same thing as last year. The same money. The same groups will get the money to the same level of funding. But instead of three applications, one, for example. It's a very different proposal than last year's buckets.

SENATOR GIPSON: Okay. Last year the Tick-Borne Disease Institute received $50,000. Is that the amount of money they're going to receive again this year?

COMMISSIONER SHAH: I can't say. I don't know what they're going to ask for or what their scope of proposal is. But on average -- our intent with this was to make sure that every group who gets funding from the Department of Health in those various buckets continues to maintain that level of funding, but with administrative

simplification.

SENATOR GIPSON: Does it make sense to you, when the CDC comes out and says that we have 10 times more cases of tick-borne illness in the country, knowing that New York State is one of the leaders in tick-borne illness, that this is an epidemic that's really rising here within our state, we have the opportunity to be a leader in trying to bring some kind of resolution to it to help those that are really suffering right now, does it make sense to you that we only gave them $50,000 within the State Health Commission's budget last year? That seems like an incredibly small amount of money.

COMMISSIONER SHAH: It does seem like a small amount of money. But it's also about -- not that there's 10 times more cases, it's that there's 10 times more recognition. So it's the cases have stayed the same, we just understand the problem is bigger than it was.

And so what we will do is work within

our systems and with our partners to make sure that we use every available tool to address it. There are now, today, compared to five years ago, many more opportunities to get lab results together in ways that we didn't before. Our Wadsworth lab does a lot of the testing specifically around this. So we're actually looking to make the program better at many different levels, and I'm happy to brief you on that at your leisure.

SENATOR GIPSON: You know, I along with many other people here have various bills in that would propose that we increase the funding to do research and preventative measures for tick-borne illness. Would you support an increased measure of funding, a substantial increase, say a million dollars' increase to this issue?

COMMISSIONER SHAH: You know, I support -- to the extent that I support for SCIRB, for prostate cancer, for cystic fibrosis, for sickle cell. There are many competing issues. And I am in favor or supporting anyone and everyone who can show

what they're going to give as a result of it. And --

SENATOR GIPSON: Can I ask -- sorry. Thank you. Can I ask, how much money are we spending on the health study for fracking? I can't seem to get a number on that. What is the total that we've spent to date on studying the health impact of fracking?

COMMISSIONER SHAH: We've spent hundreds of thousands of dollars.

SENATOR GIPSON: So we've spent hundreds of thousands of dollars studying a substance such as natural gas. We can't drink it, we can't use it to irrigate our crops. But we're only spending $50,000 on researching something like tick-borne illness which is affecting people right now? I mean, right now people are really, really suffering from this disease.

I would hope that you would advocate for an extreme addition to the funding that we're currently providing and allow New York State to take the lead in really trying to help those people that have no other place

to look right now.

COMMISSIONER SHAH: Thank you.

SENATOR GIPSON: Thank you for your time.

CHAIRMAN FARRELL: Assemblyman Crouch.

ASSEMBLYMAN CROUCH: Thank you, Mr. Chairman.

Commissioner, thank you for your time here.

About four years ago I had some health facilities in my district that were cited for some violations of how they disposed of pharmaceuticals, which they thought they were doing the correct thing at the time. But it was noted that at that time there were different regulations with DEC, the Department of Health, and even from the federal government on disposal of narcotics, especially in regard to flushing.

And my inquiry at that time, I was told that DEC and DOH were working to consolidate their regulations and make them consistent. Has that been done? Are there

still differing regulations as far as pharmaceutical disposals?

COMMISSIONER SHAH: I'm not aware of that very specific regulation. I know that what we have done over the past year is we've made many more places that can accept pharmaceuticals. For example, working with the State Police on disposal of pharmaceuticals, working on take-back programs with pharmacies, working to advance the opportunity so things aren't left in the medicine cabinet or flushed down the toilet. Educating people that when you're done with them, bring them back, not flush them down the toilet.

I can't speak to that specific regulation. I can look it up and get back to you.

ASSEMBLYMAN CROUCH: It's not a specific regulation, but it's a number of regulations, in my understanding, of how you handle and dispose of pharmaceuticals, whether it's DEC's regulations or the Department of Health. And I was told at the

time, anyways, that DOH and DEC were working and trying to make everything consistent and obviously trying to bring the federal narcotics in involved in it, because they have some different regulations on top of that.

So one other thing. In my district we have one of the veterans' homes. And I've been there a number of times, beautiful facility. And I will say that there's a lot of dedicated staff there that do a great job in caring for our veterans, and the veterans all seem to be very happy and healthy and very content where they are.

Occasionally when I'm visiting a veteran that I know, there's a comment that they're short-staffed. I just want to put in a plug that these are our veterans. And I guess a question, are there open slots at any of our veterans' homes that aren't being filled because of a hiring freeze or anything that you know of?

COMMISSIONER SHAH: Not that I'm aware of. I know that we have staffed up

Helen Hayes and our veterans' homes over the past year and a half. I can certainly look into it further.

I know that we are also in the final stages of hiring two people to oversee all of our facilities, and they will have an opportunity to take their own firsthand look at the veterans' home.

ASSEMBLYMAN CROUCH: And I'll be honest, the one gentleman I talked to hadn't made a comment in probably at least a year at this point in time, so the staffing might have been fulfilled.

And I just -- these are our veterans, these are World War II, Korean veterans that fought for our country, and they are near and dear to all of our hearts. So I would just hope you'd take that into consideration and make sure that the staffing levels are appropriate so they're not getting stressed out and our veterans are getting the care that they really need.

Thank you.

COMMISSIONER SHAH: Thank you.

CHAIRMAN DeFRANCISCO: Thank you.

Senator Krueger.

SENATOR KRUEGER: Good afternoon. I thought someone else would ask this question so I could take my name off the list, but they didn't, although many of my questions have already been answered.

The Governor is proposing in the Executive Budget the creation of the Basic Health Plan within the ACA. And my understanding is that that could actually help us increase coverage for a large number of New Yorkers who are quite poor, between 133 percent and 200 percent of the federal poverty level, but not currently eligible for insurance.

Could you explain a little bit about why you think this is actually so important?

COMMISSIONER SHAH: Why that is so important? Yes, it is absolutely important. The problem is we're waiting for the feds again, for their guidance, after which we can actually advance the program.

And this is going to be, again,

another example where the system currently has a lot of gaping holes in it in terms of coverage. And this is one of those that we need to do a better job on. The existence of such a Basic Health Plan will help with the continuum of coverage across our populations across the ages. And it will be a high-quality health plan.

So our hope is that we'll get federal guidance soon and we can start ramping up the BHP program. The reality is we can't do anything until we get more from the feds in terms of very specific guidance around their program.

SENATOR KRUEGER: Do you have an estimate of how many New Yorkers could be covered by this program if the feds go forward?

COMMISSIONER SHAH: I'm sure that Donna Frescatore has that number or Jason Helgerson has that number. I know it's a significant number.

And I also know that this will also help with New York State's current system of

funding, where a lot of people will be transitioned into this high-quality basic health plan.

SENATOR KRUEGER: And in fact I guess two groups had done some modeling before the ACA started, and they were estimating we could have state savings up to $900 million to a billion dollars. Do you know if your department can confirm that it could be this large at this point?

COMMISSIONER SHAH: I've heard north of $300 million. But then that would probably also reflect a ramp-up period, so I don't know where that would land.

SENATOR KRUEGER: And do we have any estimate of when the feds might be letting us know? Because that's not part of the Medicaid waiver we're waiting for, right, that's a different --

COMMISSIONER SHAH: No. Everyone is waiting for this, and that's part of the problem.

SENATOR KRUEGER: Okay, got it. So we don't know. And if it happened tomorrow,

could we start to implement in the new budget year?

COMMISSIONER SHAH: I doubt it, given the nature and the complexity of the program. Obviously it's in everyone's benefit. So to the extent that the sooner we get the guidance, the sooner we'll ramp it up as quickly as possible. That's our intent.

SENATOR KRUEGER: Thank you.

CHAIRMAN FARRELL: Thank you.

Assemblywoman Rosenthal.

ASSEMBLYWOMAN ROSENTHAL: Thank you, Dr. Shah, for your previous comments. A lot of people in my district and a lot of people -- which is the Upper West Side and parts of Hell's Kitchen in Manhattan, they are very concerned about their drinking water. But not just that, they're concerned about the impact of fracking on the entire state.

So I know you've been asked questions about the health study. I know DEC held hearings to get input and got tens of

thousands of comments about the fracking. But for the health study portion, did the Health Department conduct any kind of open hearing to receive comments about it?

COMMISSIONER SHAH: No.

ASSEMBLYWOMAN ROSENTHAL: So you don't have to, under the process.

COMMISSIONER SHAH: I was just asked a very specific series of charges by Commissioner Martens, to review the state of the SGEIS and to give recommendations on its adequacy relative to protecting the health of New Yorkers.

My health review will do that. I will deliver it to him when I am comfortable, at which point he can decide what he wants to do with it.

ASSEMBLYWOMAN ROSENTHAL: Okay. So when was that begun? When did that process begin internally?

COMMISSIONER SHAH: November of not last year but the year before.

ASSEMBLYWOMAN ROSENTHAL: November of 2012?

COMMISSIONER SHAH: Yes.

ASSEMBLYWOMAN ROSENTHAL: Okay. So can you describe how that process has been going on in your office, like who's assigned to it, how many people are assigned to it, what is the scope of their investigation?

COMMISSIONER SHAH: So the scope of the investigation has been publicly described and we have talked about the specific charges of what we're looking at. We're looking at ongoing existing studies that impact health related to high-volume hydrofracking. To the extent that there were over 40 such studies published last year alone, we are reviewing them.

And we have adequate staff, between ourselves and others, to make sure that we understand each study as it comes out relative to its pertinence to New York -- you know, is this a study done in 1996 when they were using very difficult chemicals in a very different place. Does it relate to Marcellus Shale or is it different sets of conditions relative to ours?

So we've had a series of questions that we've been asking. As studies come out, we look at its relevance, we look at its pertinence, we look at its actual health relevance, and we're starting to put together our understanding across all areas of health: What does high-volume hydrofracking impact and, if it does, how do you mitigate it, what do you do with it? All of those questions are in the public debate already.

ASSEMBLYWOMAN ROSENTHAL: How many staff members do you have dedicated to this study?

COMMISSIONER SHAH: It varies depending on when. So early on we had more, and now we have fewer, to the extent that it varies over time as new studies come out. We're also working with our federal partners, we're working with folks in Pennsylvania, we're working with folks in California and Illinois and Texas. It varies depending on the studies that come out. As they come out, we bring appropriate

attention to them.

ASSEMBLYWOMAN ROSENTHAL: Okay, I appreciate that, but I'd like to know in terms of sheer numbers. Do you have three people in your office or, you know, 10 people? Can you give me a better picture?

COMMISSIONER SHAH: It can be up to several dozen people. It can be as few as maybe half a dozen on any given time.

ASSEMBLYWOMAN ROSENTHAL: Okay. There were some recent reports, I think it was about Pennsylvania, that animals were dying. And it is the veritable canary in the coal mine, although these are land animals who have been affected by the water runoff that's toxic and they've been exposed, they've been drinking it, and other scenarios.

Do those kinds of things trouble you?

COMMISSIONER SHAH: Animals dying absolutely trouble me.

(Laughter.)

ASSEMBLYWOMAN ROSENTHAL: Well, I

didn't mean to throw you a softball, I meant in relation to the adverse affects of fracking in those areas where there has been fracking and then the runoff or what scientists say are the result of fracking that has directly affected the lives, health of the animals.

COMMISSIONER SHAH: We're looking at all available evidence that potentially could impact on our review of human health. So to the extent that there are studies that are very good, and there are studies that are very bad, we are reviewing all of them.

ASSEMBLYWOMAN ROSENTHAL: What's a bad study?

COMMISSIONER SHAH: A bad study is one that has no relationship to what might potentially happen in New York. A good study is one that has potential impact on human health, well described, well characterized, with conditions similar to New York State.

ASSEMBLYWOMAN ROSENTHAL: But conditions in New York State aren't set yet,

right?

COMMISSIONER SHAH: That's exactly the point. That's why I'm not done yet.

ASSEMBLYWOMAN ROSENTHAL: Well, I mean, which comes first?

COMMISSIONER SHAH: It's a work in progress. To the extent that you -- you know, what I've said in the past is that with human health I'm not willing to take any chances. And I will take the time it takes. There are, for example, large studies coming out from the feds on water impacts related to health.

When there is a tipping point of data that can point you one way or another, my report will be ready. As of today, there is no tipping point.

ASSEMBLYWOMAN ROSENTHAL: Can you describe what the tipping point might be? And I'll tell you why I keep asking you this is because so many people around the state are very anxious to hear where this administration comes out on this issue. You know that there's a wealth of opposition,

there are some who are for it, but those of course usually have a personal stake in it or a monetary stake, as in the corporations.

But, you know, if this goes forward and there's a mistake, it's not something we can take back. So I understand your interest in having a robust study come out.

COMMISSIONER SHAH: So to the extent that as we have -- we're guided by the science. We attempt to do what we do in a space where we're objective, we're clear, and it's reproducible. To the extent that when we're done anyone can challenge any or all of our assumptions, that will be an opportunity for you and everyone else to say this works, this doesn't work for me.

Right now it's very emotional and we're staying away from the emotions, we're sticking to the science as much as possible. I don't have a date because I don't know if the one definitive study on health is going to come out tomorrow or it will never come out.

The reality is there is an

accumulating body of evidence, it's changing over time. The studies that you refer to go back to 1996 in terms of human health. There are other studies that are more recent. The nature of the industry has changed over time. It is a moving target. And so I don't have a tipping point clarified until I see it.

And the point is it will be public at some point. When it is public, everyone will have an opportunity to look at all of the assumptions, all of the studies included, and challenge any or all of our findings.

CHAIRMAN FARRELL: Thank you.

ASSEMBLYWOMAN ROSENTHAL: Wait, I'm sorry, I have one last -- one sentence. My one final thing is I have a packet here of 150 peer-reviewed studies that just came out in 2013 compiled by physicians, scientists and engineers for healthy energy. So I'd like to submit them on the record for your perusal and the people in your department to look for. They are recent studies which I

think will be helpful in your study.

COMMISSIONER SHAH: Thank you.

(Applause from audience.)

CHAIRMAN FARRELL: Thank you.

CHAIRMAN DeFRANCISCO: I have a few questions, and Senator Hannon will close for the Senate when it's our turn again.

First of all, I can't let this early childhood intervention nonpayment or late payment issue go by.

Last year when you were here Senator Hannon asked some brilliant questions about the implementation by April of last year and you said there would be no problem with that. In October, that's six months later, I wrote a letter to you basically talking about exactly what everybody was complaining about today: Payments weren't being made in time. What you said at the hearing certainly didn't happen. In fact, it still hasn't happened.

You know when I got a response to that letter? Two months later, during which no doubt providers went under. Two months

later. I kept calling, getting some bits and pieces.

I mean, is there some reason that the Legislature can't get answers on a timely basis from your office?

COMMISSIONER SHAH: I certainly hope not. I mean, that's something that we --

CHAIRMAN DeFRANCISCO: Well, this isn't the only area. Let me get next to the point I want to raise.

You said that right now we're happy to report 91 percent of something was being paid. In what period of time were they being paid from the time of submission to the time of payment?

COMMISSIONER SHAH: This was data as of last week. So to the extent that there was a lot of catching up to do, I can't tell you on average whether it was two weeks, two months or two years.

CHAIRMAN DeFRANCISCO: So what does 91 percent mean?

COMMISSIONER SHAH: It means that compared to historical levels a year ago,

where we were before any of this started, a year ago how many people were paid, that's the rate we're paying them out today.

CHAIRMAN DeFRANCISCO: Exactly. But over what period of time? You may be paying them, but it may take six months, eight months, 12 months. What's the time frame in which they're being paid now? If I submit my bill and I'm a provider, as of today, when will I get paid?

COMMISSIONER SHAH: Depending -- again, we will -- I can share with you the data that we have. I think that --

CHAIRMAN DeFRANCISCO: No, no, I want to hear it now. I don't want to wait to share with us like you're sharing everything with all the questioners here. I'd like to know if -- you knew you were going to get a question on this, there's no question. So can you make a phone call, while Senator Hannon is answering the question: If I put a bill in today as a provider, when will I get paid? Can you make a phone call or find out if you don't know right now?

COMMISSIONER SHAH: It will depend -- yes, but it will depend on the type of provider you are, who you're getting paid by, which part of the state. And that's part of the problem.

CHAIRMAN DeFRANCISCO: Well, tell me each type of provider and what the time frame is for each type of provider. Can you get that information? There can't be an infinite number.

COMMISSIONER SHAH: I'm happy to provide that information.

CHAIRMAN DeFRANCISCO: Okay. And will you ask somebody to get it now so when we get done with the questions I'll ask you for that information?

COMMISSIONER SHAH: Brad Hutton is in the audience, and we will ask him to follow up and see what he --

CHAIRMAN DeFRANCISCO: And I'll be asking you that again.

The other question that I really -- you know, Brooklyn has a strong delegation in the State Legislature. And I look at

these numbers of the monies that have gone into saving Brooklyn hospitals. It is unbelievable. It is truly unbelievable. I know upstate in Syracuse we merged one hospital with another, so we have three hospitals rather than four. And they're cutting beds on a daily basis.

Let me just read you something that really caught my eye. "In recent months employees at a Central Brooklyn Hospital have come to know a level of adversity uncommon even in the crisis-bound world of New York City's health-care system. As the hospital has repeatedly run out of money for even basic supplies, doctors at Interfaith Medical Center have pitched in to purchase everything from medicines and sutures to replacements for the hospital's antiquated and often-broken equipment. Interfaith is suffering more extremely from the woes," and it may go out of business.

This was in the *New York Times,* March 20, 1989.

And since that time, money has been

thrown in and thrown in and thrown in to hospitals in distress. In 2010 there was a merger with LICH. Any logical human being would have seen that that was impossible, that you were buying a dead hospital with millions of costs and making the rest of the system pay for that incompetence and inefficiency. There had to be a solution other than just create a bigger problem.

So what I'm asking you now -- and what bothers me most, and this is why I'm so agitated about this, upstate there's a world other than Brooklyn and other than New York City. And these hospitals are getting cut year after year after year. They consolidate, they try to do things more efficiently. And rather than rewarded for their competence, additional money keeps flowing into these loss leaders without a plan that makes any sense or that you're willing or somebody's willing to implement.

So what do I tell people at the Upstate Medical Center, at the other universities that have hospitals? What do

we tell them as to why this is a fair system?

COMMISSIONER SHAH: With the DSRIP, with the waiver, we are going to be tied to very specific deliverables by the federal government. Dollars will flow based on meeting objectives. Dollars will continue to flow if objectives continue to be met.

So to the extent that there are objective criteria that the feds are going to hold us to -- we're not going to get the $10 billion as a check. We're going to get money to make transformation and as transformation proceeds, only then will more money flow.

So this is an objective criteria outside of New York's control, negotiated with the feds to transform systems, not save hospitals.

CHAIRMAN DeFRANCISCO: Do you have the objectives right now, the --

COMMISSIONER SHAH: The objectives, the very specific high-level objectives have been agreed to. Reductions in hospital

admissions and --

CHAIRMAN DeFRANCISCO: Do you have something in writing to that effect?

COMMISSIONER SHAH: Well, no, that's the point, is we haven't gotten the waiver or a commitment letter from them.

CHAIRMAN DeFRANCISCO: When you get that --

COMMISSIONER SHAH: Within 30 days.

CHAIRMAN DeFRANCISCO: -- could I have it? Okay. When you have it, would you get that to me?

Now, what about those hospitals that I've been referring to before that have done the right thing? And the state says you've got to consolidate, you've got to operate more efficiently, you've got to cut the beds, you've got to do everything necessary to make yourself -- now they're done, they've done it. What do they do, just sit by while more money is being spent?

COMMISSIONER SHAH: No. Good for them. And they shall continue to succeed. And they will be recipients of the

$1.2 billion. And there is more than enough hospital admissions that still need to be cut out of the rest of the state that they won't also have a chance at this money. The federal waiver will be statewide.

CHAIRMAN DeFRANCISCO: So they have to show additional efficiencies to what they've performed up to this point to get more dollars?

COMMISSIONER SHAH: There are vast underserved populations of behavioral health all across the state.

CHAIRMAN DeFRANCISCO: That doesn't answer my question. My question was simply this --

COMMISSIONER SHAH: That's an example of what the upstate folks can do to draw down funding.

CHAIRMAN DeFRANCISCO: The specific question was the efficiencies that they've already accomplished to this point in time, they will not be rewarded for those under this new series of dollars, is that correct? It's just what else they will do?

COMMISSIONER SHAH: I think that's not the -- the way I would phrase the question is slightly different.

CHAIRMAN DeFRANCISCO: No, I'm asking the question. You phrase the answer. You phrase the answer.

(Laughter.)

COMMISSIONER SHAH: It's not about being punished for doing good. They've also been recipients of billions of HEAL dollars over the last few years. So it's not fair to say that it's been a level playing field.

On the other hand, they will have opportunities to draw down capital and other --

CHAIRMAN DeFRANCISCO: I'm going to read -- I'm not going to read them, but the numbers here -- you're talking they're recipients of some dollars -- pale in comparison to some of the hospitals we're talking about. Pale in comparison. So the fact that they'll get some -- I would like to see some regional balance and rewards for efficiencies for the hospitals that already

did what they were supposed to do. No, that's not a question, it's just a point.

Lastly, you know, we've got people sitting here with signs. Their arms are getting tired.

(Laughter.)

CHAIRMAN DeFRANCISCO: You've got oil companies that are wanting answers and so forth. Now, you say: I'm going to take as long as I'm going to take for public safety. God bless you. But at what point does the public get to know what information you have presently, what information you're gathering, what information else that you need to make that decision? Or do we just say, Hey, as soon as he's ready, we'll just wait?

COMMISSIONER SHAH: It's a good question. And --

CHAIRMAN DeFRANCISCO: It is a good question. Now give a good answer.

(Laughter.)

COMMISSIONER SHAH: To the extent that we are taking a very aggressive

approach to try to get as much information from every potential source, from experts, from my going out in the field, from -- and trust me, people don't hold back with information. Those 130 papers, I've probably got them about seven times already.

On the other hand, to the extent that we are getting this information, we're sifting through it as quickly as possible, you will have a full opportunity to look through all of the data --

CHAIRMAN DeFRANCISCO: After you've made a decision.

COMMISSIONER SHAH: After I deliver my report.

I am not making a decision. I am delivering a report to Commissioner Martens.

CHAIRMAN DEFRANCISCO: And do you have -- no, nobody wants to rush you. But every health commissioner has a longevity here, you know. And it may be --

COMMISSIONER SHAH: What do you know that I don't know?

(Laughter.)

CHAIRMAN DeFRANCISCO: I've seen them come and go under good and bad circumstances, and one real bad circumstance.

But in any event, you must have some estimate. You're a researcher. You're a researcher. You do these studies. That's your profession. You must have some time frame that you can give us as to when you might have enough information. Because you're right, the report you're waiting for may never happen. Just -- just a ballpark.

COMMISSIONER SHAH: So I've been in trouble with giving a time frame in the past. I will --

CHAIRMAN DeFRANCISCO: I think it was weeks, last year you said weeks.

COMMISSIONER SHAH: That's right.

CHAIRMAN DeFRANCISCO: But seriously, do you have any idea? People want to know.

COMMISSIONER SHAH: Yeah. I don't -- it's not in the near future where I can predict it. I can't say that it's going to be this month.

CHAIRMAN DeFRANCISCO: All right. Somehow I expected that answer. Thank you.

CHAIRMAN FARRELL: Next, Assemblyman Aubry.

ASSEMBLYMAN AUBRY: And I can say good afternoon, Commissioner.

You had an earlier discussion about school-based health clinics, and I was wondering what percentage of junior high and high school children in the State of New York have access to those clinics.

COMMISSIONER SHAH: A very small number. I would say in the single digits that today have access to school-based health centers.

The reality is different parts need it differently. So to the extent where there is a suburb that has very high levels of affluence that everyone is getting commercial-based insurance, they may not need the same level of school-based health or they may not benefit relative to another area where they have no access and the social determinants of health really are

working against them.

ASSEMBLYMAN AUBRY: So it leads me to the question of whether or not the Health Department has a current study of disparity relative to healthcare in this state.

COMMISSIONER SHAH: We even have a task force looking at disparities of health across the state.

ASSEMBLYMAN AUBRY: And when was the last time they issued a report relative to that disparity?

COMMISSIONER SHAH: Related to obesity, it was just a few months ago.

And to the extent that now with the Medicaid redesign we are actually collecting data for the first time ever on race and ethnicity and language across all of our programs, we'll have a much richer data set to address disparities across all our programs.

ASSEMBLYMAN AUBRY: And when will that be issued? Following our concerns about other reports that have to be issued,

when will that come out?

COMMISSIONER SHAH: Well, the data is ongoing, collected on an ongoing basis and released regularly as well. So if you go today to *healthdata.NY.gov*, you will be able to get from our SPARCS data set a lot of the data that you're interested in.

ASSEMBLYMAN AUBRY: As legislators, we have to have information in order to make decisions about how you spend your money. How do we do that if we don't have accurate information at the time that decisions are being made?

COMMISSIONER SHAH: Well, I'm happy to provide you with any information you'd like at any time.

To the extent that we are actively interested and involved, with Yvonne Graham leading the charge in my office to work on issues related to disparities and minority health, this is something we take very seriously, something that the system has engaged in because they also understand the missed opportunities of keeping people

healthy and lowering costs.

Our vision of the Triple Aim fundamentally requires addressing the social determinants of health and minority health. We're very interested in including these issues.

ASSEMBLYMAN AUBRY: So we'll look forward to getting some contact with them, and a communication.

I'd like to switch up to what is the relationship between the health services provided by the correctional institutions of this state and your department.

COMMISSIONER SHAH: I am actively involved with communication with folks in Corrections, both in prison and in jails, on the health services provided. They have been leaders in telehealth, for example, which we can learn in the rest of the state from the experience of prisons and jails.

On the other hand, there are also opportunities that we're working on right now where, when folks are released, they have a continuity of coverage through

Medicaid. And so there are several issues we're working on together to improve the continuity of care.

ASSEMBLYMAN AUBRY: The status of HIV and hep C in our correctional facilities, how is that going and are we -- that work that you indicate is going on relative to individuals who are released, the connection between community healthcare providers and those who may be leaving those facilities with either one of those diseases?

COMMISSIONER SHAH: Absolutely. And we're very lucky and proud to have more work around hepatitis C recently, not just HIV and AIDS, with additional aggressive testing and now new treatments available for the very first time. Lots of folks have been waiting for these treatments for hepatitis C, and we look to expand treatment so that folks can get -- many more will even be cured.

ASSEMBLYMAN AUBRY: Are individuals with hep C and incarcerated now receiving those treatments?

COMMISSIONER SHAH: My understanding is that the very newest treatments have just come out over the last few months. I'm not aware of whether they're being used or not. I anticipate that as part of any comprehensive program they would be. I don't have the answer to that; perhaps Corrections does.

ASSEMBLYMAN AUBRY: In the past, I was aware that individuals who were incarcerated weren't being treated and were deferred treatment because of the problems with the nature of treatment.

So would you be the responsible party to ensure that individuals who were suffering from hep C received that treatment while they were incarcerated, as opposed to waiting until they were released?

COMMISSIONER SHAH: As a physician and as a doctor, as the State Health Commissioner, I'm looking to improve their care and I'll work with DOCCS. I can't say that legally I'm responsible for their care, but I would do anything and everything in my

power to make sure that they have the full spectrum of services that they need.

ASSEMBLYMAN AUBRY: Why wouldn't you be legally responsible, as Health Commissioner, for ensuring that our citizens -- they are citizens -- receive the same kind of quality of care anywhere they're located?

COMMISSIONER SHAH: I agree with you. Absolutely, we should ensure the highest quality of care regardless of location. And more importantly for that population, it's about continuity. They fall out of the system when they get discharged, they fall out of the system from prison to jail to community. And it's those continuities, those handoffs, which is where we're spending time to make sure --

ASSEMBLYMAN AUBRY: I'm concerned about the legality issue here. Do we need to change the law to make you the responsible health professional for the care of individuals who are incarcerated, if it is not now you?

You are someone who is vetted by the Legislature to have your job. The health commissioner or the health provider for DOCCS is not so required.

COMMISSIONER SHAH: I believe I am responsible.

I believe that I will continue to do what I have done, which is meet regularly with folks at all levels, to continue to visit Rikers Island and other upstate facilities, as I have done, to continue to make sure that the gaps in care are addressed, if they exist, and that we can continue to be the national leaders in providing high-quality healthcare across the continuum.

ASSEMBLYMAN AUBRY: Thank you very much.

I'll just only tell you that being a leader on this issue may not be so great, considering the state of healthcare around the country for individuals who are incarcerated. So we want to be more than just a leader. Thank you.

COMMISSIONER SHAH: Thank you.

CHAIRMAN DeFRANCISCO: Senator Hannon to close on our side.

SENATOR HANNON: Thank you, Commissioner. Your patience is really admirable, and as is your eloquence. You're certainly not the commissioner from two years ago.

I have a number of different things to ask, because this is a chance for the Legislature to raise all the concerns. And no matter who the Governor is, unfortunately we don't get the response but for the budget cycle.

I would note for the record I was very pleased for a couple of things that you've been doing. The prevention agenda, which the department did on its own, I think sets great goals, great metrics, can lead the state to new things in terms of health.

You're going -- the Governor has proposed the Organ Donation Registry in a public/private partnership. We're already the least successful organ donation state in

the nation, and we need to ramp that up. And I was glad you made that initiative.

You've been very cooperative in regard to all of our questions and information about Lyme disease and what the department is doing. It goes much beyond the research. Obviously, though, there's more to be done, which is why we have a task force.

But there's a few other things that I have. In no particular order, I wanted to back up Senator Young's concerns about the Lake Shore Hospital situation, the Pittsburgh Medical system.

I think that as you look at the approaches that have been taken in Chautauqua County by an out-of-state medical system, each of the individual ones may be appropriate under our current statutes, but the sum total of it means we could lose control of the healthcare delivery in that area. And I don't know whether it's a bistate that it has to be approached, but I do know that I think it's imperative that we

continue to search for what can be done in our whole western part of the state.

You made a note in regard to the exchange, that you said it's high-quality and low-cost, and you might join in a few years. I would tell you not yet. Senator Golden was much restrained. We've had a roundtable and a hearing in regard to how the exchange is rolling out, and people are really at a loss, at a loss for the money they didn't expect to pay, at a loss for the doctors they don't feel they can access anymore -- or they don't even know this yet, what drugs they can get.

The metrics of this have really been set by the federal government, and in fact some of the enrollment that's been impeded in New York has been that they don't have a Spanish website. Now, there's information in Spanish. But if you want to go through and enroll, that's not there. And given our population of people who speak Spanish -- and probably there's 22 other major languages that ought to be addressed -- we

really need to move forward, and they are the bottleneck on that.

Basic Health Plan. Senator Liz Krueger raised this. I would say the outside studies that were done were done on a different foundation and suppositions. I would look for a lot more serious work as to whether or not there's savings that can be made and there's better healthcare. We've been very supportive in the Senate Republicans to advance increased coverage, but I'm not convinced on this. Despite the wonderful name, Basic Health Plan, it's not so basic, it's not so simple, and it's very complicated.

We certainly want to get that care to the population affected. I'm not so sure this formula is the way to do it. And the numbers to date they've had to change because the federal government has changed it, and we have to go back and take a hard look at that.

The $1.2 billion. I don't want to say this, I don't want to throw a wet

blanket on the situation. But I would hope that if the federal waiver doesn't come through that we would still be able to have a capital program in this state to provide monies for the hospitals that need it. And I don't mean just to go to the traditional list of Brookdale, Interfaith, Kingsbrook, LICH and University Hospital at Brooklyn. We obviously have hospitals throughout the state.

And that's why last year we championed critical access hospitals under the VAP program. There was an agreement for $5 million, but not a nickel of that has flowed. And we have hospitals in the North Country, which you had a commission on, up and down the Hudson River, the western part of New York, not only Chautauqua but up in Erie.

So there is a need to really address this all over the state as well as address what you just talked about before, the public perception of if you get a waiver and you cut down hospital admissions, you're not

going to need buildings that are empty, and what will happen to all of that.

One thing we haven't talked about at all today is the impact on the healthcare system if the proposed closure of psychiatric hospitals is carried out. I have only seen some partial plans. I am told there's money that's going to follow the patients, but I haven't seen anything concrete. I think any action would be far too premature.

And especially in looking at the different areas affected, I don't know what's going to happen to the safety nets for those who need psychiatric care, especially on an acute basis, especially children. Because to a person, anecdotally but more than just a few, ask hospitals are you prepared, do you have capacity, can you do anything, and they all say "We do not have the capacity to do this."

And so we've been marrying the mental health system with the health system, both under Medicaid and combined services, look

at what we're going to do for the new proposed -- the HAARPS and things like that is, and behavioral health plans. But the whole discussion in regard to psychiatric hospitals is as if the regular physical health system doesn't exist. And it's mind-boggling.

Global cap. I want to keep coming back to that, I'm going to keep coming back to that. We don't know -- we need to know exactly how it works, who makes the decisions, a debate on the policy as to how much the increase is going to be, who gets the money from the increase.

And the fact is there's some money under the global cap that's being moved into the general budget. And when this last happened, oh, eight years ago with some HCRA money going to the general budget, I was told, "Oh, it's just a one-shot." No. It's continued. Hundreds of millions of dollars have been taken from healthcare, put into the General Fund.

I really think we need to have the

mechanism of the global cap set out explicitly so that people know where the money is going, what the expectations are, what type of recoupments might be in order. You already have, in current law, the power to take things back. Well, there's been an introduction of transparency, the cap's published monthly, but not the mechanism of the cap. And I think that's what needs to be done.

COMMISSIONER SHAH: Thank you.

SENATOR HANNON: Pharmacy. I view the movement back and forth about prior authorization as pretty much illogical. It's the nicest word I can use. We now have other changes. I think we're going to have to visit that.

And then this whole -- you spoke eloquently about making sure that we don't overpay, that we do the wholesale average cost. That's all well and good, but I've seen some detailed papers that say if the department would stick with a survey, that's fine. But by the time you get through their

footnotes where they can delete this, adjust this, add this, it's really a quite subjective system that doesn't meet the goals that you've set out.

There's an entity that's related to the Health Department called HRI, Health Research Institute. It's kind of a mystery, it's over there, it gets all of the grants that are available under NIH and DOH and a few other of the major foundations. It doesn't come through the budget. But it is a vital aspect to where the department goes.

I got some mail over the weekend that said, out of nowhere, all the people who work for it have been told they're losing their health insurance. Not reduced, losing their health insurance. And they'll get a one-shot health savings account which, when used up, will not be replenished. We're tossing them out to the exchange, if they're eligible, to the private system which we already have problems with.

I would just think that this needs to be reviewed. It's not good management.

It's not fair. And it's going to lead to I think adverse results as you're trying to tap into the people who have research and academic expertise and are there.

There's a thing that goes on in the budget where when we look at the pools, we'll restore those pools. We'll look at what the monies are. Well, when we did that last year, the 80 into 10 that we rejected, those monies have yet to flow. And it is very disturbing that we get in healthcare policy the budget dictating what goes out. And if we do as a body agree, executive and legislative, to have those monies flow, I think that that should happen.

And then the claim this year in negotiations are, Oh, by the way, if it doesn't flow within one year of being adopted, then it lapses. That's not state law. And what people are proposing to do with reauthorizations has not been our tradition. If the department is lax in getting contracts out the door and can't get it implemented the same budget year, we

don't expect to lose that money. But that's what's being said.

Last year I started everything of I want an annual report. I got six pages emailed to me two weeks ago. It's not enough. There is a richness of data on the website. There is a need to take and tell a story to the people of this state, and to the healthy community here and in the nation, what's been going on.

As I said before about big proposals such as the SHIN-NY or the global cap, PowerPoints are not enough. I mean, there's just a need to take the expertise that we have and to make it happen. And that's with your *NYdata.gov*. It's great. I just wish you had a search engine that worked, because you can't find anything there. Sometimes it just gets way old.

And so I thank you, and keep up the good work. And I just want to tell you something. There's been a phenomenon about healthcare in this state, and a current, that we've never seen before in the last

three years. Your Medicaid director, Jason Helgerson, has been in the room for three hours and he hasn't said a word.

(Laughter.)

COMMISSIONER SHAH: Thank you.

SENATOR HANNON: Thank you.

CHAIRMAN FARRELL: Thank you, Senator.

Doctor, the New York State Prostate Cancer Research Detection and Education Fund, I want to talk about that a little bit. According to an article in the *Rochester Democrat and Chronicle*, there was about $3 million that have been raised since 2005 for prostate cancer research on the return checkoff. No awards or grants have been made, and none of the funds have been expended to their intended use.

I understand the Governor's budget does include language to address the issue. What is that?

COMMISSIONER SHAH: So as you may know, the law was very explicit, unfortunately, when it was written. It

named the people who had to get the money. And this group is now some group in California that it just doesn't make sense that this group get prostate cancer money.

What we've done in the Governor's budget is address it by getting rid of that specific naming of the individual group, allowing it to have a broader applicability to actual groups that are in New York and also working to get the council that advises on where money should be spent for cancer research, from breast cancer and others, to also include one person who's living with prostate cancer, along with other expertise, so that we can actually expend the money this year appropriately as New Yorkers wish when they check off that box.

CHAIRMAN FARRELL: Because I have the bill that would do what you say you will do in the budget.

COMMISSIONER SHAH: Yes, it's there.

CHAIRMAN FARRELL: So we'll be watching it.

COMMISSIONER SHAH: Thank you.

CHAIRMAN FARRELL: Thank you.

Dick Gottfried, to close.

ASSEMBLYMAN GOTTFRIED: Yes. By the way, just one follow-up on our earlier discussion about off-label prescribing. I've just been rereading the Clinical Drug Review Program. It's a perfectly fine tool for you to accomplish everything that you said you wanted to accomplish, and is consistent with the Governor's desire not to have to deal with the Legislature, because we enacted it several years ago for you.

The proposal to reestablish regional health planning entities in New York. In your testimony you said that you were modeling this on the Rochester entity, which I think is a good idea. The Rochester entity of course is organized under the Health Systems Agency Statute, which also has been on the books even longer than the 1980 medical marijuana law.

I'm wondering whether you intend to simply use that HSA law to create entities that are exactly modeled on the Rochester

system or whether you intend to create some new entity that will have no statutory existence, no legislatively approved provisions governing their structure or who can be a member, et cetera, but will just be ad hoc entities that exist under -- I don't know what power you would use to recognize them. So why not simply use the HSA law, since that is the model on which the Rochester organization is built?

COMMISSIONER SHAH: You know, I think that's a good idea. I just suggest that different parts of the state will have very different needs. And whether the HSA law works everywhere is not clear to me.

For example, right now with the North Country Commission we have the right mix of people doing incredible things in a very short period of time. To the extent that they may decide that some form of that -- or their successors -- is the right regional planning entity for the North Country, I don't want to box them into something that doesn't work for them.

Our outcomes is how we're going to define what a RHIC is. How can you move us toward the Triple Aim? And backing into that, what do you need, what do you have, what can you contract out in terms of data, analytics, et cetera, to get to that Triple Aim?

So I envision a process where it may be something like the P2 collaborative reenvisioned in Buffalo, FLHSA is certainly on the board. It could be one of the AHACs.

ASSEMBLYMAN GOTTFRIED: Well, the HSA law has room for flexibility in it. What you're describing is a system in which the public and it matters to me that the Legislature will have no input whatsoever in what you choose to create or what the next Health Commissioner chooses to create. You know, we're supposed to be a government of laws.

Has the department done an analysis of the HSA law to document its lack of flexibility? And if so, can I have a copy of that?

COMMISSIONER SHAH: I'm not aware that we've done it. I just know that by the existing number of HSAs today, that for whatever reason over time it hasn't met all of our state's diverse needs. I'm very happy to have fully included --

ASSEMBLYMAN GOTTFRIED: Well, they went away for a very simple reason. The Legislature pulled the plug on the money. And so all of them, except the Rochester one, over a year or two withered and died. No mystery to that. They had served the state for over 20 years pretty well.

So again, I don't understand why you wouldn't make use of a statute already on the books and just reignite or, you know, reenliven HSAs by providing money to them, since it was the lack of money that killed them.

COMMISSIONER SHAH: I'm happy to look into that further.

ASSEMBLYMAN GOTTFRIED: Thank you.

CHAIRMAN DeFRANCISCO: That's it.

SENATOR HANNON: Could I just add a

sentence?

CHAIRMAN DeFRANCISCO: One sentence, right.

SENATOR HANNON: I'm concerned about the recent interpretation of the ability of Licensed Home Care Agencies to deliver the services, and I believe if left unchecked you'll have a very dis-settling ability to help the elderly in this state.

COMMISSIONER SHAH: We're absolutely meeting with the representatives to look at that very closely within the next week.

CHAIRMAN DeFRANCISCO: Thank you.

And now you're going to give us the answer to that question. And then we will go on to the next witness.

The time frame from billing to payment at the present moment in the State of New York.

DIRECTOR HUTTON: I apologize for stepping out for a few minutes, Senator DeFrancisco. I needed to check to be sure that I'd properly --

CHAIRMAN DeFRANCISCO: That's all

right. Just give me an answer. Everybody's getting antsy. We can't wait. We can't wait.

(Laughter.)

DIRECTOR HUTTON: So an important metric that we've been following --

CHAIRMAN DeFRANCISCO: No, no, no, no. Just -- please, just give --

DIRECTOR HUTTON: Okay, here we go. Ready?

CHAIRMAN DeFRANCISCO: Yeah.

DIRECTOR HUTTON: Claims submitted in May, right immediately after the transition, the rate that were adjudicated within 60 days were only 55 percent. More recent months, in August that increased to 83 percent, in September to 84 percent, in October to 85 percent --

CHAIRMAN DeFRANCISCO: And now 9.1.

DIRECTOR HUTTON: -- November claims, 88. This is the percent that are adjudicated within 60 days.

This actually represents an undercount, because these are only the claim

adjudication responses that we know about. We're still working with the insurance industry to get additional responses out there that are not known to us.

CHAIRMAN DeFRANCISCO: Okay. Adjudication and payment two different things; correct?

DIRECTOR HUTTON: Well, adjudication immediately precedes payment. And so --

CHAIRMAN DeFRANCISCO: And how much time, normal time presently between adjudication and payment?

DIRECTOR HUTTON: What I have ready is the percent adjudicated. We'll be happy to calculate that for you with the data. We have the data.

CHAIRMAN DeFRANCISCO: Okay, please provide that to me, because I think my question was very clear, from bill to payment. But -- and I'll provide it to everyone, okay? Thank you very much. I appreciate it.

Doctor, thank you for spending this amount of time with us, this quality time.

I appreciate it.

CHAIRMAN FARRELL: Thank you very much.

COMMISSIONER SHAH: Thank you. Thank you very much.

CHAIRMAN DeFRANCISCO: The next speaker, who's been anxiously waiting, James C. Cox, Medicaid Inspector General.

Okay, can we please begin with the next witness, because it is going to be a late hour and he deserves our attention. Thank you very much.

Okay, Jim Cox.

MEDICAID IG COX: Chairman DeFrancisco, Chairman Farrell and distinguished members of the Senate Finance and Assembly Ways and Means Committee, Health Committee Chair Hannon, and Assemblyman Gottfried, my name is James Cox and I am the Medicaid Inspector General. I want to thank you for the opportunity to discuss the 2014-2015 Executive Budget as it relates to the Office of Medicaid Inspector General.

I appear before you today with important information about OMIG's performance during the past year, and to demonstrate to you how New York State's investment in OMIG has paid off. I also appear today to present the status of OMIG's efforts as we look forward into 2014-15.

OMIG was created as part of an overall effort to reduce fraud, waste, and abuse within the Medicaid program. The intent was to become more proactive in fighting fraud and also to detect and prevent overbilling. We have made tremendous progress in both areas.

I come today to tell you that OMIG achieved record recoveries in 2013. These results reflect an ongoing focus on fighting fraud and recovering payments from improper Medicaid billings. Our preliminary statistics indicate that OMIG's health care fraud enforcement efforts resulted in more than $851 million recovered in the last calendar year. This improves upon our previous record by more than $347 million,

and continues a trend of strong recoveries.

Over the last three years, the administration's enforcement efforts have recovered $1.73 billion, a 34 percent increase over the prior three-year period. As reported in our most recent annual report, we completed 4,400 investigations, also a new record.

OMIG is very fortunate to have some of the best employees in the state. We have staff with extensive experience in Medicaid. We have some of the state's longest-tenured and skilled auditors. We have investigators whose collective knowledge encompasses hundreds of years of investigative experience. We have data mining and collections staff who are second to none. We have the first and, we would argue, the best compliance unit in the United States. Each of these disciplines come together to create the leading state Medicaid program integrity unit in the nation.

It is important to state that OMIG remains an independent oversight agency.

However, it must continue to be knowledgeable about the Medicaid program requirements. Maintaining constructive relationships with other parts of government is a crucial component of success. To that end, we have worked with other state agencies to strengthen our understanding of regulations and their application to the Medicaid program.

Further, we have emphasized the importance of working with law enforcement. As an example, OMIG, the Department of Health, and the Attorney General's Medicaid Fraud Control Unit recently revised a memorandum of understanding that will help New York comply with provisions of the Affordable Care Act, strengthen our enforcement capabilities as they relate to managed care, and improve our state's ability to fight fraud in the Medicaid program. The Medicaid Fraud Control Unit personnel recently described its relationship with OMIG as "the best it has ever been."

OMIG is proud of its County Demonstration Program achievements over the past year. This program works to fight fraud and abuse at the county level. Over the past year, we have redesigned this program for success by more than doubling the staff assigned to the program and working more collaboratively on a regular basis with our partners. In addition, we have held quarterly meetings with the demonstration participants and are beginning the process of opening new areas for review.

As a result of our efforts, we have begun to get positive feedback from our partners at the local level. To quote one of them: "As the year closes out, I wanted to thank all of you for your great support this year. Thanks to your assistance, we go into 2014 in very good shape."

The County Demonstration Program has also started to show important program integrity results. As an example, just two weeks ago Erie County reported that their local efforts netted more than $300,000

returned from inappropriate billings and several cases of fraud. We are firmly committed to the continued success of this program.

Improved relationships have also helped us in our work to fight fraud over the past year in the social adult day care area. OMIG, the Department of Health, the Office for the Aging, and the Medicaid Fraud Control Unit worked together to investigate allegations of ineligible individuals being enrolled in the Medicaid program. Through this work, OMIG anticipates substantial recoveries. We believe that the effort to improve our work with the Medicaid Fraud Control Unit and other partners is a benefit that will continue to yield results.

In the past year, we launched a new web site that keeps providers, taxpayers, businesses, and consumers informed about Medicaid program integrity. We now have 20 active audit protocols that providers can refer to. We are very proud of this work because it has a positive effect on the

state's program and fiscal integrity.

At OMIG we recognize the importance of identifying areas for potential fraud or abuse and of working with providers to prevent improper conduct before it starts. We value the importance of having a presence in the field. That is why we sent people into the field to review social adult day care. It is why we sent people out to investigate medical transportation. It is why we lead the nation in conducting pharmacy inventory reviews. It is why we work shoulder-to-shoulder with providers, consumers, and taxpayers to learn firsthand what is going on at the grassroots level.

We have increased our commitment to compliance and education programs, and these efforts have also proven successful. As a reflection of this, we set a record in our last annual report for self-disclosed dollars, with over $20 million recovered.

The coming year presents new opportunities. The Executive Budget represents a strong commitment to our office

and will improve OMIG's operations and its ability to fight fraud and abuse in the Medicaid program.

Thank you for the opportunity to speak today. I am happy to answer questions.

CHAIRMAN DeFRANCISCO: Senator Hannon.

SENATOR HANNON: Thank you, Mr. Medicaid Inspector General. The Legislature is eyeing constructive uses of those increased recoveries because we're certainly going to have a tussle with the Division of Budget, but you have opened up new opportunities.

I'll make a comment. The communication has been pretty good, but I think there is a need to increase the level of awareness of your office. Certainly somehow just, you know, at 2:30 this morning the *Daily News* reported on your recoveries. Not a coincidence that was budget hearing day. And last month you finally issued the report on VNS, which had been much bandied

about in the papers.

But I think it's about also what you mentioned about Erie County, I think it's really incumbent to up the game throughout the state with local county attorneys or local DAs, local Social Service Districts, to try to let the public know that in a program that's spending $54 billion a year of state, local and federal money in this state that you're continuing to be active and continuing to do it.

Compliance programs and telling them what to do is fine; they'll still mess it up. But we need to see that level of penetration so people see something. I had more comments, down from the territory where I am, about what Erie County was doing in that one small announcement that they had than any others that have come about.

So that's the direction. I don't know if we put the same language in the budget that we did last year or not. But that's the direction we want to go as we go forward with this budget.

MEDICAID IG COX: Thank you, Senator. I agree with you.

CHAIRMAN FARRELL: Thank you.

Assemblyman Ra.

ASSEMBLYMAN RA: Thank you, Chairman.

Good afternoon. Just a quick question. I know you highlighted the record recovery, and it was in some of the newspapers this morning as well. And I just was wondering if you can comment on some of the new efforts in assuming new technologies and efficiencies that are resulting in some savings, because we did notice in the budget that there's about $10 million less than the Executive Budget proposal for the audit and prevention program.

MEDICAID IG COX: Yeah. First of all, let me talk about the record-setting recoveries that we had. There was a large dollar amount that we recovered from the federal government that related to dually eligibles, those individuals that were eligible for both Medicaid and Medicare services, and what was determined that

Medicaid paid them initially and Medicare should have paid them.

So working with the demonstration program, we were able to get the federal government to pay the money that it should and reimburse the state. In fact, $211 million the federal government paid the state for that.

We are using all sorts of technologies, and I agree with Senator Hannon when he talked about working closely with the folks at the county level. It's a fundamental belief of mine that the people at the local district know what's going on, they know the type of fraud that's going on in their area, and it would be a shame if we were not to utilize the expertise and the knowledge that they have at the local level.

Some of the other changes that we've made, we've posted our protocols online. We've educated our investigators and our auditors. I firmly believe that we know what we're doing before we go out into the field now. And we also have -- and it's

preliminary numbers as well, but not just our recoveries, but our audit finding numbers are significantly higher this year as well. So that should funnel recoveries in for the foreseeable future as well.

We are using technology to the best we can. And we have great data-mining staff that are working today in and day out to do specific matches and where best to recover monies.

ASSEMBLYMAN RA: Okay, thank you.

You know, and I know this has been talked about a lot over the last few years, but recoveries are great and they're important that we especially work with the county levels who are seeing what's going on in their local counties. It helps us obviously recover significant amounts of money that can be put back into healthcare.

But at the same time I think utilizing the latest technologies we have to uncover and prevent the fraud from happening in the first place so we don't have to actually spend the additional resources to

go get that money back certainly will benefit the system as a whole, particularly on the provider side, utilizing the technology we have to make sure that people aren't billing for services that aren't rendered, overbilling and all that.

So I thank the department for their efforts.

MEDICAID IG COX: Thank you.

CHAIRMAN DeFRANCISCO: Senator Golden.

SENATOR GOLDEN: Thank you very much there, sir. Thank you for your testimony here today. I just have a few quick questions.

I had asked the Commissioner before how the I-STOP has limited the number of what I see Oxycontin and prescription drug that's in my community, but I do see an increase in the heroin in Nassau County, Staten Island, Westchester, Brooklyn and across the downstate, and I'm sure upstate as well.

Are you observing the same, and is

there any approach that your office is dealing with that?

MEDICAID IG COX: We're paying close attention to what's going on in the pharmacy area, and that's why we have a specific business-line team that's dedicated to look at trends that's going on in the pharmacy area.

But, you know, heroin is a different story. It's certainly something that I read in the newspapers. To be honest with you, relatives, friends of ours, family members, it is a problem.

SENATOR GOLDEN: But are the numbers down across the state on the barbiturates and narcotic prescription drug use?

MEDICAID IG COX: Yes. We're still paying close attention to it because I feel very strongly that it's something that we can make a difference on.

And in fact I challenged our business-line team to come up with an approach, and we developed the inventory reviews where we go out and we spot-check

the drugs that are on the shelf, we compare them with the billings that were billed to the Medicaid program, we compare it with the invoices where they purchase the drugs. And if there's too many drugs sitting on the shelves, we know one of two things, that you billed us for drugs that you didn't provide or that you issued the drugs and brought them back in the back door.

And we've done a significant number of inventory reviews in the last year, and we will continue to do so.

SENATOR GOLDEN: I come from the fraud capital of the country, Brooklyn, New York. Unfortunately it's something that I don't really like to brag about or talk about, but it's the truth. And if we take a look at the mills that we have going on in Brooklyn, we have quite a few of them. And so your task is before you.

Are we still using -- I know you have a number of investigators, you have hired new people. Are we still doing auditors? Are we still doing private outsourcing of

audits?

MEDICAID IG COX: Yes, sir. We're very active in the Brooklyn area. We participate in the federal government's task force. We have undercover investigators. We have contract investigators now in place that are bilingual, many different languages. And we have undercover shoppers all over the New York City area.

SENATOR GOLDEN: Your undercovers are working specifically in pharmacies and licensed premises or in mills themselves that are set up?

MEDICAID IG COX: Yes, there's a number of them working in that area.

SENATOR GOLDEN: So you're not doing street activity, street buys or anything like that, you're going to find out -- where the 68th Precinct comes up with a kid with 60 pills, are we going in to find out where that kid got those 60 pills from?

MEDICAID IG COX: We offered to work very closely -- and are working, in fact. I met with the Brooklyn district attorney last

year, the prior one. And we are working very closely with our local district partners. Because once again, I believe that that intelligence from the street has to be relayed up to us and it's something that --

SENATOR GOLDEN: We don't have anything set up with NYPD per se as to go -- you don't have the staff, I would imagine, to be able to do that, do you, to go in there to find -- you're just working with the district attorney's office, you're not working with the NYPD themselves to find out if we take down a 60/80, 200, 500 pills, Oxycontin? Are you be debriefing any of these individuals?

MEDICAID IG COX: Again, we participate, we work closely with the special prosecutor for narcotics in the New York City area as well, and we have the sharing of information.

On a national level, we were the first state to join the Healthcare Fraud Prevention Partnership, where there's

sharing of information.

We established a memorandum of understanding with the Health Department where we can now get data that's other than Medicaid when it comes to pharmacies so we have a better understanding of the full picture of what's going on in the pharmacy arena.

SENATOR GOLDEN: Last question -- two questions.

The actual investigations and the audits that you come in with, there is obviously a dollar amount when the purchase goes down. How much are the counties getting, those district attorneys? Have we come up with a number that we give them on a takedown if we recover $200 million? Do you -- I understand you did -- by the way, very proud of the work you have done and the amount that you've been able to seize and bring back into government.

Are we actually splitting with our DAs? What type of percentage are our DAs getting for working with you?

MEDICAID IG COX: The monies that I recover go back into the -- offset the global cap.

SENATOR GOLDEN: Is there a number to that global cap?

MEDICAID IG COX: I have a target each year. This year it's $1.1 billion to identify as cost savings and cost recoveries.

SENATOR GOLDEN: And so that incentivizes, okay. That's it. Thank you very much. I appreciate your testimony, and I'm looking forward to working with you over the course of the year. And hopefully we will get not only the Oxycontin and the prescription barbiturates under control, but start to work on the next issue, which is going to be heroin in our communities.

Thank you.

MEDICAID IG COX: Thank you, Senator.

CHAIRMAN FARRELL: Assemblywoman Gunther.

ASSEMBLYWOMAN GUNTHER: Hi, how are you. I just have a quick question about the

medical transportation.

Since we have changed like the way that we provide medical transport, we have to call to Syracuse now, and it comes from just one agency. And I guess some of the comments that I've heard is that it's one of the more inefficient systems because actually someone in Syracuse doesn't know Sullivan County or Orange County. So if you're on a route, like they computerize -- they don't have like a computerization that if you call and I call the next person.

So I guess I'm asking you, have you saved any money? It was supposed to be done for a cost-saving measure. And have you saved any money? And the complaints that I hear is like inefficiency.

MEDICAID IG COX: The cost-savings money that you're referring to is probably reflected in the global cap, in the controls that the Health Department is reporting on. So we don't double count our cost-savings money. The Health Department has certain cost savings that they report to the

Division of Budget. I would not take credit in OMIG's reports for that type of cost savings.

When I say we look at medical transportation, we actually did a joint workforce with the New York City Taxi and Limousine Commission, with the federal government Centers for Medicare and Medicaid Services, went out into the field. I liken it to the DWI sweeps. On a real-time basis we went out, we pulled over the medical transportation vehicles. We ascertain whether the driver was properly licensed, the vehicle was properly registered and properly inspected. To me, it's paramount --

ASSEMBLYWOMAN GUNTHER: I think I'm more focused on where it says waste. Waste, and that's what my focus is.

Because if they go to Grahamsville -- I mean, they don't know how to map out a trip. So I think that we're spending more money than necessary. When we have three people going down to Hilltown -- and now

more than one person can ride in a Medicaid cab. You can't put Medicare and Medicaid, don't ask me why, together when they're going to the same destination.

But I think that what I've heard and what I've -- there's a lot of waste. Because they don't have like a computer system, they randomly pick people up, they're spending tons of money on these cabs. And, you know, when the cab driver drives down, they wait like an hour. If it's an hour ride away, they're waiting there. And again, they're not utilizing it in the way that I really thought it was going to do something positive.

So -- and I know you take care of waste, so that's something that I think would be something to look into.

MEDICAID IG COX: Okay. Absolutely. Thank you.

CHAIRMAN DeFRANCISCO: Okay, last question or two. You talked about the recovery, and they are admirable. And you said that it goes back under the cap.

Correct?

MEDICAID IG COX: Yes, sir.

CHAIRMAN DeFRANCISCO: What cap? For 2013-2014 or 2014-2015?

MEDICAID IG COX: It goes back into -- I'm sure it goes back into the time in which it's deposited. Those funds are deposited into a special what we call 169 account. So any monies recovered today would go towards the 2013-2014.

CHAIRMAN DEFRANCISCO: Okay.

Secondly, when you first got into your position there was a big furor of providers that felt that your office was much too aggressive and there was no -- there was even bills about some type of due process and so forth. I haven't heard a word over the last year, so that means you're doing something very, very right. And I want to compliment you for aggressively going after these recoveries but also doing it in a way that's a professional way that the providers seem to be content with.

Thank you.

MEDICAID IG COX: Thank you.

CHAIRMAN FARRELL: Thank you.

CHAIRMAN DeFRANCISCO: All right, the next speaker is Dennis Whalen, HANYS.

ASSEMBLYMAN OAKS: And while he's making his way here, Assemblyman Graf has been with us, and we heard from Assemblyman Ra, who joined us as well.

MR. WHALEN: Good afternoon, Chairmen DeFrancisco, Farrell, Health Committee Chairs Hannon and Gottfried, and members of the Senate and Assembly.

I've submitted our formal testimony, and I will simply do a quick summary today.

While every budget is important, this one is especially so because it comes at a critical time for healthcare. We're in the midst of transformation, as Dr. Shah talked about, driven by technology, by increased coverage, payment reform, new models of service delivery, an emphasis on population and community health, and changing patient needs.

Hospitals are embracing this challenge, not running from it. But it is a difficult time. And I find myself in the unusual position of actually quoting the Governor and Commissioner from Budget Day when they talked about the financial condition of the state's hospitals. There is no question that the healthcare system in New York State is fragile. We have the third worst operating margins in the country, the number of hospitals in shaky circumstances is growing. Dr. Shah in his presentation that day said that the department's review showed that nearly half of the state's hospitals are financially distressed.

So you've seen the pace of consolidations and closures increase. This is as impacts the result of actions in Washington are drawing millions of dollars out of hospitals, and the confluence of other factors. And I'm sure that each of you probably does not have to look very far to see troubling indicators among the health

providers that serve the communities that you represent.

So the Executive Budget proposed by the Governor is welcome. It's an essential ingredient. We thank the Governor for his proposals and his recognition of the need for support. Elimination of the 2 percent across-the-board Medicaid cut that began in 2011, the new $1.2 billion capital program, the increase in funding to the Vital Access Program, all of these are essential ingredients in our mind.

I also add my voice to that of others urging you all to add your voices to our Congressional representatives, the White House and others for immediate approval of the state's $10 billion Medicaid waiver, and also emphasize, as a number of you have mentioned today, that this needs to be a statewide waiver. Brooklyn is important, it is time that we solve that problem, but there are other problems in the state that need to be addressed as well.

This budget, importantly, also starts

or at least initiates a methodology for shared savings. So to the extent that we stay under the cap, a method for sharing that savings with providers as well as to fund transformation efforts.

But as Senator Hannon and others have indicated, I think in the face of that it is critically important to advocate for transparency of the cap, to understand how the flow of dollars into the cap works.

There are a number of pressures on cap this year. Dollars are scheduled to go toward the General Fund. Home care wage parity and other elements will place pressure on the cap. There's increased enrollment as a result of the ACA. So understanding how all that works is key to understanding whether there's a promise there and when it will occur in the form of shared savings.

There's the start in this budget of regulatory reform. And I'd say that it's a modest start. I'd say that it's insufficient when it comes to leveling the

playing field. I think Senator Young used that phrase earlier today. More work is needed in this area because a key reason that hospitals are facing the difficulties that they face has to do with an unlevel playing field, where there are parts of the healthcare system that are not subject to the same level of regulation and requirement and process as hospitals and other licensed providers.

They are free to compete in the marketplace, and most often they compete by taking those patients who have good health insurance coverage, leaving other providers with an increasing concentration of patients who are paid for by government or maybe self-pay or uninsured.

You know, hospitals and health systems have a special role. If we were just competing, you know, in a peer market environment, I suppose that kind of approach would be fine. But we require our hospitals and health systems to do different things than simply act like they are part of the

marketplace. Right? They deliver a series of public goods that we rely on them to do. They're open 24/7, 365. Anybody who needs those services can walk into those emergency rooms and get them.

They're there to, you know, provide effective emergency treatment, trauma designations. They're there to deliver babies. You know, 50 percent-plus of the deliveries in this state are Medicaid. And Medicaid and Medicare to hospitals pay less than cost. It's well documented. You hear MedPAC in the federal government talk about it all the time, you know, 86 or 89 cents per dollar is what's reimbursed.

And so the ability to have a good payer mix is critical for those hospitals to be able to fulfill the mission to provide those public goods that we ask them to do.

Now, I said hospitals are embracing change. There was some discussion that concerned me because I want to dispose of the idea that hospitals are not a critical ingredient in primary care. You know, for

every patient that's in a hospital bed receiving medical care, there are eight patients who are getting primary care from that hospital.

And that's because hospitals in certain urban areas and suburban and rural areas are the primary care providers. That's because there's simply insufficient supply of other primary care providers or there are geographic or access issues in rural communities and elsewhere where it's difficult to attract health professionals.

So as we go forward there's no question, I think, that transformation means hospitals will look different. And we shouldn't focus on the four walls or the bricks or mortar, because in the future they're going to probably be more about cooperative care, working in partnership, you know, improving quality and safety, keeping our communities and patients healthy. We will still expect them, under any plan I've ever seen, to be that constant, to be that thing you can rely upon

for those urgent, critical, necessary services that aren't available elsewhere.

And I think we have to keep our eye on that ball because all of these changes that we make are not unrelated, detached issues. It all goes to this question of whether we are changing the system in ways where hospitals will be unable to support that mission, you know, doing those things that we rely upon them to do.

Our submitted testimony includes coverage of a number of issues which we look forward to working with you on during the session. And I'm happy to answer any questions.

CHAIRMAN FARRELL: Thank you very much.

Senator?

SENATOR KRUEGER: Senator Hannon.

SENATOR HANNON: Mr. Whalen, so you're all in support of this initiative for a waiver whose avowed purpose is to decrease hospital admissions by 25 percent in five years and 50 percent in 10 years? How do

you harmonize that with the fact that you have heat to pay for and lights to leave on and all that?

MR. WHALEN: Those things that occur on an annual basis which we used to cover through a trend factor but no longer do.

You know, every waiver that the federal government has given out in the recent period has this as a key ingredient, sometimes with more aggressive measures in terms of the amount of admissions they are decreasing.

And look, you can look at any set of measures about where New York is on hospital beds per thousand, on admissions per thousand patients, and see that we are above the national average. Hospitals are working hard to decrease those beds, to decrease length of stay, to improve quality, safety. So hospitals are already working to decrease admissions. In fact, you know, the hospitals that I talk to around this state, you can see now, you know, anywhere in certain parts of this state a 10 to

15 percent decrease in terms of acute care census over the recent periods for hospitals.

Now, you know, it's very hard to identify why that is happening. Is it as a result of these other services becoming available in a community, is it the result of prevention efforts that are working, is it a result of the economic situation where people are deferring certain levels of care?

But from the hospital point of view, we are now shifting from this question of volume to value. And so that's really where the emphasis is going to be, keeping communities healthy, keeping people out of the hospital. You know, what's the exact right setting to provide the intervention or the treatment plan that you need for that individual.

So I think hospitals will embrace this challenge. The question we will keep returning to, however, is as these changes take place in the healthcare system, what's our expectation for hospitals? What's our

expectation about them being there to provide the set of services that we want? And, if so, how do they cover the overhead to make sure they can continue to do that?

SENATOR HANNON: That's my biggest question, is the tension between the two. At the same time you're facing helping in a waiver, and it may -- some people have said this may be happening anyway, but you find CMS, the federal government, the federal agency that sets the rules for Medicare, doing a couple of things that again cut into the cash flow to hospitals.

The whole thing about the two-midnight rule, which I think they've just suspended for six months --

MR. WHALEN: Another six months, right.

SENATOR HANNON: -- or the penalties for excess readmissions. Once again, that's cash out of a hospital's pocket.

And I just wonder if we need some type of score card as to what the obligations are. Because we still have a

charity-care requirement on hospitals, and we still have a community action -- in fact, it's been increased this year, a community action plan on the hospitals because it's part of the prevention agenda.

So it's a question of where you go. And then at the same time, which becomes a politician's problem, is when somebody in the community goes, You can't close that. You can't cut that down. You can't curtail that service. And if you don't, you know, we're going to have a protest against you.

MR. WHALEN: Yeah, I'd say two things. One is it is just as important for the State Senate and Assembly to pay attention to what is happening in Washington on healthcare as it is to pay attention to what's happening in-state.

And the reason for that is you cited two examples. But we're headed into a time period now where there will be several occasions -- debt ceiling, doc fix and other events -- where Congress will be trying to solve financial problems. And we had the

unfortunate circumstances a couple of weeks ago where the Congressional response to an extension of unemployment insurance was to say, We'll just push out the Medicare cuts a few more years on providers.

So a complete detachment from the source of funding to the purpose. And we cannot survive and sustain that. The recovery audit contractors, the observation rules, the two-midnight, they are pulling millions of dollars out of New York hospitals. And the process to appeal those decisions is so long as to have hospitals be unable to receive a date from the federal government as to when their case will be heard.

And in the meantime, your dollars are gone, recouped and tied up. You don't get those back until the end of the appeal process. And by the way, hospitals win an extraordinary percentage of those appeals, but in the meantime they are suffering the absence of those dollars.

We, Greater New York, Mt. Sinai and

others are bringing a lawsuit against the two-midnight-rule provision, but we need to pay keen attention to that. Because, you know, when I talked to the Health Department a few months ago when they were developing sort of measures to determine how can we tell when hospitals are going to get in trouble, it was completely blind to the federal impact. You know, they looked at lots of information that they had, but unless you have that perspective in mind you're going to be woefully misled as to how serious things are.

SENATOR HANNON: I could ask you lots more, but I won't.

MR. WHALEN: Thank you. I appreciate the time.

SENATOR KRUEGER: I actually have one question for you, Dennis, I'm sorry. The issue came up before -- I'm sorry, one second. And I didn't assume no questions from the Assembly.

So under the ACA, some of the hospitals are not participating. There was

the story today about the Westchester hospital not participating. What's the solution for making sure that there is adequate hospital inclusion in this new program that we assume will be covering more and more New Yorkers?

MR. WHALEN: Yeah, I did see the story; I did not read it in detail. So I think the hospital's response was that the rates being offered to them were insufficient for them to take on the risk of providing the service. And the dilemma, of course, is that they are one of those places that provides some of those services that we rely on to be there and to be essential.

Dr. Shah indicated that he would take a look at that. We'll talk to the hospital as well to see if we can determine what the fact patterns are. You know, a little bit depends on, you know, who's in the network.

And what I will say about this is I think the state deserves great credit for getting the exchange up and operating smoothly. That's key and important. But

now is also the time, that it is doing well, to start to take a look at some of the policy issues that are raised as a result of it now being underway.

Extremely difficult for anybody -- if any of you have tried to get on there and find out who's in or not in a network in terms of physicians or institutions, very difficult. Clearly a number of proposals from the Senate and the Assembly on out-of-network and other issues that need, I think, public policy debate and attention because they will create problems down the road.

And another dynamic being, you know, what is the predominant choice of individuals', you know, coverage on the plan. Are they clustered within certain of the metal groups such that they have substantial out-of-pocket expenses? So lots of the concern on the provider side that this may lead to uncollectible debt and sort of chasing the dollar.

But I'll have to talk to the

institution to really understand their concern about the rates and the plans that are being offered.

SENATOR KRUEGER: And I appreciate in your testimony you made a series of recommendations of what we can do better now with ACA, so I won't ask questions now. But I appreciate that you submitted testimony on all those details. Thank you.

MR. WHALEN: Thank you. I appreciate the opportunity.

CHAIRMAN FARRELL: Oh, there's one more question.

Assemblyman Cahill.

ASSEMBLYMAN CAHILL: Hi, Dennis. And thank you for coming in and offering great testimony in the written comments. I read it already and read along with you.

I just wanted to focus in on one aspect of what you have indicated in your prepared remarks about regulatory reform leveling the playing field, particularly talking about the Certificate of Need process.

You're taking the position that we need to level it in terms of other healthcare providers who are not regulated in the Certificate of Need process. Would you believe that we should ease the regulations of Certificate of Need for hospitals and nursing homes? Or should we expand Certificate of Need to those entities right now who are coming into a community and sort of eating your lunch?

MR. WHALEN: Right. I think there's room to do both, actually, to really address this concern about leveling the playing field.

And, you know, I'll start by saying that the ability of those who are not licensed in New York -- so not Article 28 facilities -- to make some of the changes and take some of the actions in the healthcare marketplace, occur at lightning speed compared to the process that regulated entities need to go through. So I think there is a wide variety of CON activity which could absolutely be reduced.

I think there's a real question about whether or not the answer on the other side is should CON regulation be instituted for others. You know, there are a set of questions that got raised in the process that the department went through over the last year with its Public Health and Health Planning Council Planning Committee that I think identified the right questions but which were never answered.

So, you know, should there be an obligation on the part of some of those providers to serve the Medicaid population. I mean, we have instances upstate where individuals will appear in the emergency room with a card that says go to this address, an emergency room. And when the emergency room staff asks, you know, where did you get that, they say, well, I tried to go to the Urgicare Center but when they found out I was a Medicaid patient, they gave me this and told me to come here.

So, you know, that is an unlevel playing field. When it takes a year for a

hospital to take on a private physician practice and turn it into an Article 28 program -- a year -- it's an administrative process. That's just extraordinary.

My favorite example is a hospital in Jamestown who needed to purchase updated radiological equipment, submitted the application to the Health Department, it took one year to get the yes. In the meantime, the doctors at that hospital left, went into private practice, purchased their own radiology equipment and started to attract the commercial insured population away from the hospital into their clinic.

So, you know, I think there are some things where CON and other regulations can be reduced or the process can be changed through attestation or other things, because there's an extraordinary amount of paperwork bounced back and forth that's just sort of bureaucratic. And look, I understand the Health Department probably could use more help and, you know, it's a bureaucracy and they've got a lot on their plate.

That, to me, is a recipe not to just keep extending the timeline, it's to figure out, you know, how can we cut the Gordian knot and make some of this a lot easier where it doesn't need to be hard and difficult and be subjected to lots of reviews. There are some things where that's appropriate, but there's an awful lot where it isn't.

ASSEMBLYMAN CAHILL: Let me just briefly ask you to pick between different approaches to regional planning. Commissioner Shah has been indicating support, of course, for the Governor's proposal of replicating the Rochester area health system agency, for the want of a better term -- I don't know the actual name of it.

MR. WHALEN: Finger Lakes.

ASSEMBLYMAN CAHILL: Assemblyman Gottfried indicated that maybe what we could do is just reinvigorate our HSAs across the state by providing some funding.

Does HANYS have a position on that?

MR. WHALEN: That's a bad idea, in our opinion. HSAs are a vestige of the National Health Planning Act, from when I first started working in government in 1975. They were set up with a particular purpose; they had authorities to review and rule on CON programs. In New York State, I think one of the HSA regions actually includes three counties in Pennsylvania because that's how it got organized under the National Health Planning Act.

So I don't think the answer is to resurrect HSAs. You know, the state has been quite clear that their intent is not to have these Regional Health Improvement Collaboratives rule on CON applications or slow down sort of the need for institutions to make rapid change in response to technological developments, clinical improvements or other things. And I think that's the right answer, as opposed to HSAs.

ASSEMBLYMAN CAHILL: Thanks, Dennis.

CHAIRMAN FARRELL: Thank you.

MR. WHALEN: Thank you.

CHAIRMAN DeFRANCISCO: Senator Savino.

SENATOR SAVINO: Thank you, Senator DeFrancisco.

MR. WHALEN: I was escaping.

SENATOR SAVINO: I will try and be brief. I'm sure you can imagine I wanted to ask you a couple of questions about medical marijuana.

MR. WHALEN: Sure.

SENATOR SAVINO: As you heard Commissioner Shah say earlier, that he's been talking to hospitals about this. Has there been any discussion with HANYS about the complications that a hospital distribution plan would result in for the hospitals themselves?

MR. WHALEN: I talked to Dr. Shah a few days before this proposal came out in the press. And as a result of that, at several meetings with our membership, in various of my visits to institutions and some of our publications, we've mentioned this program. And I've heard from about a

dozen institutions who have said they are interested in the program.

Now, in some cases it's because they have a research interest. So one hospital in particular has an affiliation with a partner hospital where there is, you know, a well-known researcher on medical marijuana, so they have a particular interest. For most of them it is simply the desire to be able to offer anything to patients that would be curative, ameliorative, relieve pain, relieve symptoms.

And, you know, when it comes to how that all get structured and set up, the response really is that's for government to figure out. You know, it's not our strong suit. And so I've been pretty clear in saying to the state, you know, I've had some places that are clearly interested, they want to hear more about what your program is and how it's structured; I've had some say "I don't want to say I'm interested now, but maybe when the details of how it's structured come out, I'll be interested and

prepared to say yes."

So I think folks are waiting to see exactly what the structure and process and protocols will be.

SENATOR SAVINO: Do you have any member institutions that are not partially licensed by the federal government, federal licenses? Any hospitals that are part of HANYS?

MR. WHALEN: You know, they have so many certifications and licenses I can't imagine there isn't a hospital in New York State that doesn't get a Medicare reimbursement, for example.

SENATOR SAVINO: Right. And of the research facilities or facilities that have research programs, are most of those research grants, are they federal dollars that fund those research programs?

MR. WHALEN: A significant proportion are federal government grants.

SENATOR SAVINO: The reason I'm asking this is because of the restrictions that the federal government places on the

distribution of medical marijuana through facilities that have either federal licenses or federal research dollars.

So if we were to go down this road, it would require the state to replace all of those research dollars because the federal government would pull them. So I'm not putting you on the spot, I understand that, you know, this was kind of thrown out at many of you the same way it was at thrown out at many of us.

What I would suggest is that perhaps your attorneys prepare a reply to this proposal that the Governor has put forward and lay out very clearly the complications that they present for institutions that have federal licenses, federal dollars and also licenses to distribute other narcotics which would be at risk if you were to begin distributing a Schedule 1 substance.

MR. WHALEN: Sure. I've asked the department that question, and their response is that "Well, our intent is to get a federal IND number to conduct research."

Now, if that's how it gets structured, hospitals are pretty used to dealing with that program and protocol. And it would not create a conflict, assuming again that the federal government sort of puts its stamp of approval on the research as well as how everything gets supplied.

SENATOR SAVINO: I think the last IND approval could have been granted pursuant to this law in 1992. So I don't think we're going to see that happen anytime soon. But I appreciate your candor, Dennis, as always. Thank you.

CHAIRMAN DeFRANCISCO: Thank you.

MR. WHALEN: Thank you.

CHAIRMAN DeFRANCISCO: The next speaker is Kenneth Raske, president and CEO of the Greater New York Hospital Association.

MR. RASKE: Good afternoon, Mr. Chairman and members of the joint committee. As always, it's a pleasure being here with you to talk about the budget and state healthcare priorities coming up within

that budget, and some of the issues, as my good friend and colleague Dennis Whalen just went through with you, both in terms of his testimony as well as through the Q&A.

Our testimony is in a set of panels which I hope you all received. It's not written. It's also pictorials, which are easier for me to deal with. And quite frankly, I'll just cross-reference only a few of them as I try to summarize this in just a few minutes.

Let's start at the beginning. You know, three or four years ago we began a journey with the Medicaid Redesign Team that is so far on that journey turning out to be one of the great American success stories in healthcare reform. And that success story is predicated on some new and innovative approaches that stakeholders are taking, that the Legislature has taken, that the Executive branch has taken in cooperation between and among ourselves.

And we have done things such as institutionalize a global cap, a byproduct

of which has produced about $17 billion worth of savings for the State of New York, coequal to the federal government as well -- subject therefore to the waiver request that we'll talk about a little bit -- and also put an enormous amount of pressure on institutions to cooperate among themselves too, and to do things that we really hadn't heretofore done.

Now, in that testimony we talk about some of those things, the growth and proliferation of Medical Homes and Health Homes as well, and how New York State is a leader in that. But it also has produced enormous improvements to and collaborations among the institutions themselves, particularly on the hospital side, but not exclusively, in terms of infection control and working to improve patient care generally.

Panel 5 of my presentation has some stark statistics that involve some of these collaboratives. Some involve our good friends and partners at the Healthcare

Association of New York State. In some cases they involve also the United Hospital fund back in New York City, and in other cases they are within Greater New York itself as well our member institutions.

But some really exciting improvements have been done in infection control, reductions of injuries, and reductions in early elective deliveries as well.

So the success story is still a work in progress. And I'm not here to take a victory lap or anything even close to it, because as we begin to see, there's really a lot of trouble in River City. Make no mistake, we have some big-time problems throughout the state.

And, you know, I was looking up there at the counties of the State of New York, and you can start pinpointing all the counties that is problems. There's about 33 hospitals across the state that are on a watch list and, you know, that's hitting in 23 counties. Who might be next added to that 33, I don't know. Who's the closest to

extinction or into Chapter 11, I don't know. But nonetheless, we know that there's problems. Some are well publicized, some are not. But nonetheless, there are problems that we have to deal with.

And Senator Hannon, I want to get to your question that you asked Dennis Whalen about that, because the route out sounds like a painful way back for the hospitals. You know, and I can understand the circularity sometimes of how that looks. But we do think we have a significant rationale to figure our way out of the dilemma.

So beginning on the process I applaud the executive branch for putting before you a state budget that takes the function of the MRT and begins putting some brickwork around it. I mean we're not building a big superstructure yet here, but we're beginning to put those bricks in place.

And those bricks are solid bricks. The restoration of the 2 percent reduction in Medicaid payments, big deal. That is a

huge deal. And the global cap, when we originally talked about it -- and I think probably I said it here before you four years ago, I was talking about it should be a program that involves, yes, risk assumption on the upside and then savings to be achieved as well and to be shared with the hospitals.

Well, when that thing got passed it just -- it forgot the savings parts. But that's okay. Now we have some experience with it, and now the executive branch is putting that forward as to a retention of savings.

And then what's interesting too there, they have a 50/50 on the retention, some going back coequally to the sectors upon which it was saved and the other going to a fund that would help bail out needy institutions, whatever they turn out to be. So in any event, that would be something that we would support.

And then, perhaps most importantly, the capital expenditures part of this

budget, which is $1.2 billion over a seven-year program, $200 million I believe in each of the first five years, and then $100 million in the subsequent sixth and seventh year each, so for a total of $1.2 billion. And that really is something that is significant and desperately needed for the transformation.

So the state budget is there to begin putting that brickwork in place. Adding to now the superstructure is the waiver. The waiver is clear, it doesn't have capital money in it. And in fact, the federal government has been emphatic in all of their negotiations with our state that no capital will be part of this and none of the money, none of the money will be used for bailouts of hospitals.

This is now we're drawing closer, Senator Hannon, to the essence of your question.

So when you have a situation where you need capital and the federal government is not supplying it, well here we now have

the state stepping up to help fill that void. That's a great thing. That's a good thing for everybody in that capacity.

So then what we need to use the waiver money for is this transformation of the healthcare system, which is, yeah, how do you get from where you're at today with a certain level of admissions and defining a hospital as largely an inpatient facility with an emergency room, ORs and intensive care units, to this next generation of patient management beyond the walls of the hospitals, before they get in and after they get out?

And deal with some of the problems that are fundamental to the healthcare system which are not good, such as bouncing our nursing home patients back and forth between the ERs of our hospitals, which I think is horrible. I don't like that. And we have to get at those kinds of issues.

The waiver will get us at those kinds of issues. We've started on that road now. But I think that we can expand with

information systems, more activity in investments into out-of-hospital activity will move us to that next level.

So, Senator, what your point was is that we're redefining the hospital, and it's in real time. Now, we better redesign it and make sure that it's financially sustainable, and that was the point out that you were really driving to.

And, ladies and gentlemen, I believe that we will do that. We will have to tighten the bolts on this thing as it goes on. This is literally a work in progress. We're going to have to work in a cooperative way to fix things that need to be fixed and change things that need to be changed, because nobody's that smart to figure out what human behavior is like en masse sometime in the future. So we're going to give it the best shot we can, and I think that we will certainly get to a place that will be on target with the healthcare needs of every New Yorker that lives in the great State of New York.

Finally, on the waiver itself, we too urge everybody in New York to urge their colleagues in Washington, particularly within the administration, to really approve this thing as quickly as possible. Because you know, ladies and gentlemen, I'm not understating this one bit, but, you know, literally lives are at stake here, and it could be our loved ones.

So, Mr. Chairman, that really summarizes a set of testimony that I formally filed with this committee. And I'm proud to answer any questions about the testimony or any other subject affecting healthcare in this state, sir.

CHAIRMAN DEFRANCISCO: Thank you.

Senator Smith.

SENATOR SMITH: Thank you very much, Mr. Chairman.

Thank you, Ken, for your testimony.

Just a question on future hospitals. I'm talking about brick and mortar. I mean, given the waiver, I know the Governor had the $1.2 billion for sounds like everything

else but new construction, if you will.

MR. RASKE: Correct.

SENATOR SMITH: Southeast Queens, it's parochial to me. We've lost three hospitals over the last three or four years. The two that we have left, which is Jamaica and St. John's, as you know is bursting at the seams. And St. John's is almost on life support from month to month.

The question is, is it unrealistic to think that the potential for building a new hospital as we know in the tradition, will happen? Or is the hospital of the future going to be virtual and the size of a storefront, if you will?

MR. RASKE: You know, Senator, that's a great question. And while we talk about all this transformative theory and practice that's going on, let me be quite clear too. There will always be a need for a hospital. There will always be a need for an intensive care unit, a coronary care unit, a cancer center, and all the rest of that, because those are diseases known to mankind. So

that will always be needed.

But are there ways to help increase the efficiencies of the current healthcare system and get cases which are not of that severity either to not present themselves or not to get even worse? And the answer to that is yes. So it's possible to decant, to some degree. But we will always need to invest.

And specifically on the area that you're talking about, it is clear that capital investment in both short-term acute care as well as beyond that is necessary. Yes, sir.

SENATOR SMITH: Thank you very much.

Thank you, Mr. Chairman.

CHAIRMAN DeFRANCISCO: Senator Hannon to close.

SENATOR HANNON: Senator Savino wanted to ask a question.

SENATOR SAVINO: Not on medical marijuana. I'm not going to ask you about --

MR. RASKE: No, it's fine, whatever

you wish.

SENATOR SAVINO: -- because we've already had this discussion, and I know the answer to it, is yours is similar to Dennis Whalen's.

I actually wanted to talk to you about the hospitals situation because I think you very effectively put forward the argument that we need to rethink healthcare. The idea of having your own local hospital in your own neighborhood is something that's disappearing in a lot of parts of this state as we rightsize the system.

One of the challenges, though, that I see for our existing hospitals, particularly on Staten Island, we have Staten Island University Hospital, part of North Shore LIJ, and then we have Richmond University on the North Shore, which has gone through several, you know, changes --

MR. RASKE: Iterations.

SENATOR SAVINO: Exactly.

What we're seeing, though, in those communities, we're seeing these feeder

clinics from other hospitals, particularly the ones in Manhattan, where they're establishing local clinics and then siphoning off private-pay patients or patients that have better insurance, so that when they do need a hospitalized setting or an elective setting, they're going into Manhattan, destabilizing our local hospitals.

So this is a common complaint that we receive from Staten Island University Hospital's board, how do we rightsize a system and then not leave our large hospitals in the outer boroughs at risk to financial problems because they're left with a population that's overwhelming Medicaid or indigent care.

MR. RASKE: Excellent question. I get the same complaints too.

And the answer to it is that the Health Department has been very much aware of that and has asked for regulatory guidance from the industry even on those kinds of things, which we've all stepped up

to the plate and offered, which is somewhere in the regulatory process as well.

But fundamentally what it really means is getting hospitals to cooperate and invest coequally in areas and in ways that are mutually beneficial and not to disadvantage a party. And the trials and tribulations that they're going through on Long Island College, as an example. I mean, you know, a situation to pull in academic medical centers to help support it, or larger teaching hospitals, depending on your point of view.

I believe that that is a fundamental solution. And I think the State of New York and the State Health Department has been very sensitive to that. Has it been complete? Of course not. This is why we still have complaints about it. But the fact of the matter is there's significant movement in that direction.

SENATOR SAVINO: And finally, as you know, Staten Island was particularly hard-hit by Sandy as well as South Brooklyn

and Lower Manhattan. But our two hospitals now -- and I'm going to stick on the Staten Island side. Staten Island University Hospital is literally on the beach. And so any capital improvements, you know, that we're hoping to help them get from the federal government, it's all going to go into preventing the next Sandy and preventing that hospital from becoming completely destroyed.

It was only by a miracle that the hospital was not, you know, basically destroyed that night. But how do we protect it in the future with shrinking dollars, capital dollars for hospitals? Is there anything that you guys are thinking about in terms of securing more money for these hospitals that are right directly in the line of the next storm?

MR. RASKE: You know, we were on the front lines in Sandy. We were at Olean, we helped evacuate a lot of the places that needed to be evacuated -- nursing homes, NYU, and da-da-da-da-da-da. And we're up to

our eyeballs in it. And also on the rebuilding of those plans.

But, you know, the first thing is is you -- we have to begin planning for the next event, because there will be another event. And that's really the heart of your question. And the Lord only knows when that will be.

But in doing that, I think we're going to have to tap every source we can possibly make available. But fundamentally I believe it's got to be federal sources, because that's the size of the money that will be necessary in order to accomplish that.

And our group is committed to working on finding ways to introduce money into -- either through or about FEMA or any other federal agency that we can possibly imagine, in order to shore up these institutions against future problems.

And then, you know, the flood plain has been redesignated in New York. What was not in a flood plain area now is. You know,

hard experience, I guess, got us there. But nonetheless, it's where we're at today.

So a lot of these institutions that weren't impacted are candidates for impact. So we're going to have to deal with that. But you know, Senator, I would be a fool to sit before you and say that there was an easy answer to that question, because there is not. But the federal government fundamentally is the one that will have to do it, because they're the ones that can build the dikes and the levies and all the rest of this stuff that we're talking about. Superhuman engineering that will have to take place, or some mini-scale of that as it relates to a hospital.

SENATOR SAVINO: Thank you, Ken.

CHAIRMAN DeFRANCISCO: Senator Hannon to close.

SENATOR HANNON: Thank you.

Thank you, Mr. Raske. In light of your comments about the original part of the global cap about risks and savings and you only got the risk. But it seems to me that

we're now at a point in the budget cycle where we should put in statute a projection as to the savings you're going to get and also a question as to whether it's going to be 2 percent or whatever it is.

Because the institutions that are part of this whole process need to be able to project. And if you can only project on a 9-month or a 15-month basis, you really don't know what you can commit to down the road. And so I just think that's something that we ought to explore.

MR. RASKE: You know, I never thought of that, Senator. That's something that certainly warrants consideration. Thank you.

SENATOR HANNON: Take credit for it.

(Laughter.)

MR. RASKE: I'm going to give you credit for it.

SENATOR HANNON: Dennis will if he doesn't.

The last thing is just in terms of the comments of the $1.2 billion, there was

also provisions in the Governor's proposal with regard to private equity. And it seems to me that there are major hospital institutions that are in essence doing private equity now, but it's not necessarily available to the medium-strength and the lower-strength institutions.

And we ought to figure out some way to do that, because hospitals, nursing homes, clinics wear out and they need to be replaced.

MR. RASKE: You know, that issue has been a real pain in the neck for me, because I do have a divisiveness in the membership on that subject. On the one hand, the need and those that can put deals together, and the other hand the very legitimate concerns that ushers in the beginning of investor-owned interests into the healthcare community.

We had a struggle with the concept last year and worked on some cohesive language I think within the legislative body, and we're going to have to dust that

off and see how that meshes against the Executive's proposal.

This proposal from the Executive this time around is different. How much different, I can't --

SENATOR HANNON: One thing is they adopted our thought in the Senate that it be no for-profit corporations.

MR. RASKE: Yeah, I mean, that's a -- that's a significant issue.

SENATOR HANNON: And if other people are in doubt about what investors do, they should take a look at the bonds that are now issued by hospitals to the market and look at the bond indenture and see the latitude or lack thereof to a hospital. They have to have certain business practices, they have to have certain adherence to accounting standards. It's not for profit, it's just the people who lend money want to know it's not going to be wasted.

MR. RASKE: Yup. I understand.

SENATOR HANNON: Thank you.

MR. RASKE: Thank you.

CHAIRMAN FARRELL: Thank you.

CHAIRMAN DEFRANCISCO: Thank you. All set.

MR. RASKE: Okay, thank you, Mr. Chairman.

And thank you, members of the committee. You're always very kind and generous with your time. Thank you.

CHAIRMAN DeFRANCISCO: Christine Johnston, president, New York State Association of Health Care Providers.

MS. JOHNSTON: Good afternoon. Thank you for providing the opportunity to testify today. My name is Christine Johnston. I'm the president of the New York State Association of Health Care Providers. We represent Licensed Home Care Services, Certified Home Health Agencies, Long Term Home Health Care Programs and other home and community-based care providers throughout New York State.

You have a more detailed testimony with a lot of words there. I'm going to hit some of the highlights, three critical

issues I really want to focus on today and bring to your attention.

I think we can all agree home care is often preferred by patients and families. It allows those of all ages facing illness, disability and aging to maintain their dignity, independence, privacy and control by receiving health and support services at home. Home care also provides great value to the state. It is the linchpin in keeping costs down, preventing rehospitalizations, slowing decline and speeding recovery.

As the commissioner stated in his testimony earlier, we need to focus more on primary and home and community-based care. And yet despite evidence that greater investment in home care saves money and more options for home care are being pushed through waivers and different demonstration programs, home care programs in New York continue to be plagued by inadequate levels of reimbursement, burdensome and costly regulations, and massive system change absent the financial support or thoughtful

system transitions.

This proposed budget does begin to recognize some of the challenges home care providers are facing as state policies are implemented, but it does not go far enough.

So first on the positive front, the budget, as was mentioned before, does phase out the 2 percent payment reduction, which we wholeheartedly support. Reimbursement is limited as it is, and every dollar that we can get to the providers, to support the delivery of care is important.

Another positive, for the first time there is an effort to target funds to assist licensed agencies as they struggle through the changes that are driven by the MRT recommendations enacted in 2011. We feel it will be very important to ensure that the funding is distributed in a timely and geographically equitable manner.

There are a number of other proposals in the budget that demonstrate an interest in reinvesting in the healthcare system, which is a good thing. But home care

providers of all types and areas of the state must be explicitly included in these efforts.

But among the many issues for home care and the details in the budget, I think it's helpful to tease out three specific areas. The first is funding. It always go goes back to funding. HCP is very supportive of the investment in the budget to begin to fund the enormous increase in the New York City wage parity mandate. In Year 3 of this mandate, New York City's hourly total compensation for home care workers jumps from $10.93 per hour to $14.09 per hour, which is a total direct cost of $16.35 per hour. This is a significant increase to this community.

The cost of the increase, as the Department of Health would explain, is at least $400 million. There may be more cost attributable to that. Yet there is only slightly more than $300 million in the budget. So the funding to fund that last year increase in the wage parity mandate is

inadequate and needs to be increased.

In addition to more funding related to this, it is essential that a mechanism be in place to ensure that adequate rates are paid to the employers of the workers so they can pay the employees. Typically these are licensed agencies. And it must be done in a timely manner. Rates and premiums must be adequate, but they must then move through the system to where costs are incurred. And that's not consistently happening now.

And also we would argue that funding should be also made available for home care outside of New York City. Wage parity increases are happening in Nassau, Suffolk, and Westchester County, and will dramatically increase as well in the coming years.

And statewide minimum wage increases and other mandates, along with similar managed care transition costs, are challenging providers from Suffolk to Niagara County and everywhere in between. Funds must be made to available to support

the delivery of care throughout the state, and that is not currently done in the budget.

Second, investment of financial resources won't help unless providers are paid. The expedited transition to mandatory managed care, the movement of over 80,000 patients in such a short time, has left little time for home care providers to work with plans to address the transition challenges.

One of the most critical is to address prompt payment from many of the managed care plans. Problems persist with billing submission, codes, authorizations and other transaction and communication issues. And even if rates are high enough, payments are not timely and cash flow has been impacted. Some of these are transition issues that with more time, we could work out. But they're happening right now.

There needs to be accountability to the front-line providers like home care. They operate on good faith that the payer

will follow through; they trust that the information they rely on in the state system as to who the payer is is accurate; they provide the care; they pay the workers; and they don't walk away. But never has there been a greater unknown about whether and when they'll receive payment.

We need to look at changes in protections, whether it's streamlining the system with uniform codes, electronic funds transfer, clean claims, something to make a difference.

And finally, the surprise issue that threatens to undermine efficiencies that have been developed in the new managed care system. For the past 10 years, if not longer, managed long-term-care plans have contracted directly with licensed agencies for the full spectrum of home care services. DOH has supported and encouraged such contracting. In 2011, the Governor spoke of reducing administrative costs and eliminating layers in the delivery of home care.

These long-standing contracts with licensed agencies have reduced administrative costs and layers of contracting. And they have increased as 80,000 patients have transitioned to managed care. Providers have invested human and financial resources to adapt to the new system and ensure consumers continue to receive high quality and continuity of care.

A week ago DOH released a "Dear Administrator" letter to home care providers saying these contracts were impermissible. This directive is a major policy change, and it comes in the midst of a major transition. It was released without any guidance, no transition time, no assurances of payment during the transition, no preparation for continuity of care, and no discussion of how the efforts to streamline the system and minimize cost has just dramatically changed for all.

There are cost issues and access concerns that need to be considered. There are patient continuity-of-care and provider

transitions that need to be addressed. There are state issues and federal policies that are cited in this, and we will need your help to secure clarification, identify areas for greater flexibility, and figure out what the real impacts are to the healthcare and home care system.

Two years ago I testified on the many changes for home care that were part of the MRT recommendations under consideration. Today I've only touched on a few of the many, many changes. And during these two years so much work has been done by home care providers in a time of upheaval and without significant guidance, support or answers.

They have worked countless hours to ensure that their patients understand the changes coming at them. They have gone above and beyond to ensure that care is available. It's time some support goes back in their direction. Funding, predictable payment policies, and answers to questions. This budget is a starting place, but we hope

it is not the end.

The system changes are far from complete. Home care continues to transition with the full mandatory MLTC rollout throughout the statewide plan for 2014 and more changes to come with FIDA, BIP, money follows the person, CFCO, among all the other acronyms that apply to the home care system these days. But simultaneously, costs continue to increase with health mandates, minimum wage increases, workers' comp rates, technology investments that are needed.

And we need to invest in the home care infrastructure as we barrel forward. We need to cover the costs, we need to ensure workers are paid, and we need to ensure that home care has the opportunity to figure out how to stabilize during this transition. It's essential.

Thank you for the opportunity. Happy to take questions.

CHAIRMAN DeFRANCISCO: That "Dear Administrator" letter, when did that come?

MS. JOHNSTON: It was posted to the health commerce system to the home care industry last Tuesday.

CHAIRMAN DeFRANCISCO: Could you give me a copy of that?

MS. JOHNSTON: Yes, absolutely.

CHAIRMAN DeFRANCISCO: And secondly, you mentioned the payment situation. What is the average time frame for your members for submitting bills and payment?

MS. JOHNSTON: It varies, but we consistently hear from our members that payments are 90 days to 180 days out for different bills submitted.

It varies by provider, it varies by plan. And I think there are a lot of different transition issues that could be worked out collaboratively, but the time to do that is immediate. And that creates a lot of problems.

CHAIRMAN DeFRANCISCO: Well, if you can give me some recommendations -- you said there's a lot of ways to make it work better -- I'd be more than happy to follow

up on it.

MS. JOHNSTON: Thank you.

CHAIRMAN DeFRANCISCO: Thank you very much. And the lack of questions has nothing to do with the quality of the presentation. It has to do with the hour and what we're looking ahead at.

Elizabeth Swain, president and CEO of Community Health Care Association of New York State.

On deck is Steven Hanse.

MS. SWAIN: Hi. Good afternoon. Thank you for the opportunity to provide testimony regarding the Governor's budget proposal.

I'm Elizabeth Swain, the president and CEO of CHCANYS, the state's primary care association of community, migrant and homeless health centers, presenting a shortened version of the testimony that we've provided to you.

Through the Medicaid Redesign Team, and the state's 1115 waiver application, the Governor has clearly emphasized the

imperative of shifting New York's healthcare infrastructure from inpatient hospital settings to fully integrated primary care delivery systems.

Federally qualified health centers, or FQHCs, serve as a foundation for the sustainable expansion necessary to grow primary care, and the Governor's budget can further this health agenda.

New York State is home to a large network of FQHCs, serving more than any other state's FQHC network except that of California. Today health centers serve 1.6 million New Yorkers annually, are central to New York's primary care delivery system, and healthcare safety-net.

New York State's FQHCs have grown steadily since 2007. They serve low-income patients, of which two-thirds live below the poverty level, one-quarter are best served in a language other than English, three-quarters are racial and ethnic minorities, one-quarter are uninsured, 75,000 are homeless, and 110,000 are

elderly.

FQHCs are nonprofit patient-centered medical homes located in medically underserved areas. The community-based health centers provide comprehensive primary care and family medicine, pediatrics, obstetrics and gynecology, internal medicine, oral health, laboratory, mental health, substance abuse and pharmacy services. These extensive clinical services are supported by the health centers' community-based board of directors.

Between 2007 and 2012, patient volume increased by 31 percent in New York State's FQHCs, while this number of annual visits increased by 33 percent. Much of this growth can be attributed to the Health Resources and Services Administration through the stimulus bill and the Affordable Care Act, and to CMS through the Medicaid and Medicare expansions.

Also during this period, full-time employment at FQHCs increased by 35 percent; clinical staffing by 40 percent. By 2012,

FQHCs employed over 11,300 people, many of whom come from the local communities the health centers are located in.

In addition, FQHCs are designed to be fully integrated patients at our medical homes with mental health, oral health, and disease prevention as requisite components of a comprehensive primary care setting. And in the five-year period between 2007 and 2012, FQHC patients using mental health services increased by 70 percent; patients using substance abuse services grew by 78 percent; and patients requiring various types of enabling services, which are really population health types of services, increased by 29 percent.

As a result of these shifts in service demand, approximately 90,000 FQHC patients in New York State received mental health services in 2012; 13,000 received substance abuse counseling or treatment; and over $150,000 received enabling services.

CHCANYS, with the support of the New York State Health Foundation in

partnership with folks at the state and the city level, recently released a plan for expanding sustainable health centers in New York. The plan identifies opportunities across four domains to expand FQHC's capacity. Because even though we -- you know, we know that the coverage expansions that are coming about through the ACA implementation will go a long way to addressing healthcare inequities in our system, without adequate system reform, we won't have access to care in communities that need it the most.

So the Governor's Executive Budget advances this agenda, and with the Legislature's further efforts, we believe we can take significant steps towards developing a fully integrated primary care delivery system that partners with hospital systems and all of the other major health system partners that we are building relationships with.

Our specific comments and requests regarding the Executive Budget are follows.

We support the Governor's $1.2 billion appropriation for capital investment. However, it's critical that a significant portion of the dollars be designated to primary care safety-net providers. CHCANYS urges the Legislature to ensure primary care net providers receive a substantial portion of the proposed $200 million in annual distributions.

The Governor's budget expands the availability of the Health Facility Restructuring Program. This extension will include diagnostic and treatment centers, allowing DOH to leverage this resource for FQHCs. In addition, a capital technical assistance program should be established to help community-based primary care providers assess their capital needs, assess their risks, and identify and secure capital financing for expansions.

CHCANYS urges the Legislature to commit to a diverse and strong primary care workforce by safeguarding programs like the Primary Care Service Corps and Doctors

Across New York that advance the recruitment and retention of primary care providers. Specifically, we request support for an appropriation of $500,000, including a federal match for the Primary Care Service Corps and the provision of sufficient funding for a new Doctors Across New York class not included in this Executive Budget. Filling vacant positions is an immediate way to expand the capacity of providers to serve more patients.

The Executive Budget proposes to continue to fund a $54.4 million pool for DTC uncompensated care. The Uncompensated Care Pool for DTCs provides funding to health centers for services provided to uninsured patients, fully uninsured uncompensated patients. Though FQHCs try hard to ensure eligible people are enrolled in coverage, 23 percent of our health center patients are uninsured. This is a 6.5 percent increase over the past five years, and the number of uninsured patients at some health centers is as high as

50 percent.

CHCANYS strongly supports restored funding to previous fiscal year levels for the Migrant Health Care programs across New York State. Migrant and seasonal agricultural workers are an extremely vulnerable population. Between 2007 and 2012, FQHCs have seen a 25 percent increase in the number of migrant and seasonal farm workers served, with no increase in State funding to care for these patients.

CHCANYS applauds the state for its efforts to advance shared savings under the Medicaid global cap. However, it is critical to discuss in greater detail how savings are shared. FQHCs and other community-based providers should be included in future discussions with DOH regarding shared savings.

CHCANYS also recognizes and applauds the Executive Budget's proposal to double the appropriation allocated for the Vital Access Provider Program. The VAP program provides funds to essential safety-net

providers who care for high Medicaid or uninsured populations. Also, VAP has utility for initiatives under the 1115 waiver. For example, VAP can be leveraged within a provider's DSRIP application.

We urge the Legislature to support the reinvestment of Medicaid savings to OMH and OASAS for the expansion of behavioral health services for the purpose of increasing access to, and integrating behavioral health, including community-based behavioral health services.

FQHCs are designed to be fully-integrated Patient Centered Medical Homes with mental health as one requisite component of a comprehensive primary care setting.

The state should continue its effort to partner with community-based innovators such as FQHCs in order to build upon successful team-based integration models.

CHCANYS appreciates the opportunity to be seated on the state's Basic Health

Plan Workgroup, and would like to ensure the BHP moves forward. The Executive Budget proposes a contingent provision for a BHP to cover certain legal immigrants that would otherwise be ineligible for Medicaid. Accordingly, CHCANYS supports the implementation of a BHP. However, we request more clarity regarding premium and cost-sharing provisions.

CHCANYS urges the Legislature to support provisions for Regional Health Improvement Collaboratives (RHICs). FQHCs can be informed and innovative partners in regional health planning efforts, and their participation should be encouraged and supported.

CHCANYS strongly supports New York State's efforts towards Certificate of Need reform. As part of these activities, the budget includes the proposal to exempt D&TCs and hospitals from Certificate of Need for primary care where construction does not involve change in capacity, services provided, major medical equipment, facility

replacement or geographic location.

And in conclusion, we stand ready to work with the state leadership to expand a high quality and sustainable system at the core of New York's healthcare delivery transformation. Thanks so much for the opportunity to present my testimony to you today.

CHAIRMAN DeFRANCISCO: Senator Krueger.

SENATOR KRUEGER: Thanks for your testimony. Just two quick questions.

You talked about the importance of getting a piece of the capital money to expand on the services provided. Are you under the belief that the way the language is written in the Executive Budget you should be eligible for that money?

MS. SWAIN: Yes.

SENATOR KRUEGER: Okay. And you don't have any reason to think you wouldn't be?

MS. SWAIN: No.

SENATOR KRUEGER: Okay. Good.

Second question, you talk about the role of your network in providing mental health and behavioral health services. And I know there's so much change within Medicaid redesign on Health Homes and other managed-care models for people with mental health issues and developmental issues and substance abuse.

How does that match up with the kinds of services you're providing, or how is it a problem for you?

MS. SWAIN: Some of our FQHCs are duly licensed Article 28s and Article 31s and provide a full range of services. We have major issues with regulatory barriers to integrate a real patient-centered medical home that provides a full range of services.

So, you know, regulatory reform has to happen. We've been talking about it for several years. We need to continue to talk about it, because we do need to be able to care for the 20 percent of the patients, or fewer, that are really costing 80 percent of the dollars being spent in these settings.

So I think we're all on the same page in terms of the policy. The regulatory structure, the way we pay for these services and where they're provided are really -- I mean, the devil is in the details there. What we're doing is sitting down with all our partner associations and our partners at the state DOH and other Os, and try to fashion some solutions.

With the DSRIP dollars flowing the way that it looks like they will, our challenge is to get out in front and to try to design programs that will address the reduction in hospital admissions, while accomplishing all of that regulatory reform.

SENATOR KRUEGER: And it's state regulations that need to be changed, or federal regulations?

MS. SWAIN: State.

SENATOR KRUEGER: State.

MS. SWAIN: Yes.

SENATOR KRUEGER: So if you could provide me your proposals, that would be very helpful.

MS. SWAIN: Yes.

SENATOR KRUEGER: Thank you.

MS. SWAIN: Thank you.

CHAIRMAN DeFRANCISCO: Thank you very much.

The 11:50 a.m. speaker is next, Stephen Hanse, New York State Health Facilities Association. On deck is James Clyne.

And the future speakers, I know you guys get the short shrift because you're at the end, if you could kind of summarize your high points. It's very, very difficult to stay focused on a re-read.

Thank you. You're on.

MR. HANSE: Good afternoon, Chairman DeFrancisco, Chairman Farrell, Health Committee Chairman Senator Hannon, members of the joint committee.

My name is Stephen Hanse, and I have the privilege of serving as vice-president of government affairs and counsel for the New York State Health Facilities Association and the New York State Center for Assisted

Living.

Joining me today is Mark Olsen, administrator for Kingsway Arms Nursing Center in Schenectady, and chair of our legislative committee.

NYSHFA and NYSCAL members and their 57,000 employees provide essential long-term care to over 44,000 elderly, frail, and physically challenged women, men and children at over 280 skilled nursing and assisted living facilities throughout the State of New York.

As we sit here today, New York's long-term-care providers face significant challenges as a result of the state's transition to managed long-term care, recent state budget constraints, and certain initiatives proposed in the 2014-2015 Executive Budget.

Over the past seven years, funding cuts to New York's long-term healthcare sector have exceeded $1.5 billion. Initiatives implemented by the Medicaid Redesign Team have resulted in approximately

$500 million in additional cuts over the last two years. And the potential for additional federal Medicare cuts only exacerbates New York's already fragile long-term care finances.

For example, at $51.96 per patient per day, New York unfortunately leads the nation with the largest shortfall between Medicaid payment rates and the cost of providing necessary patient care.

And as providers enter into their sixth year without a trend factor for inflation, New York's long-term-care facilities have worked hard to endure these past budget cuts, and this is demonstrated by the fact that nursing home spending is often below the Medicaid global spending cap enacted under the MRT.

As New York's long-term-care providers enter into year three of the State's new pricing methodology for reimbursement as a transition to a managed-care environment, and continue to work with the Department of Health to

reconcile ongoing payment issues associated with Superstorm Sandy, it is critical that the 2014-2015 enacted budget provide financial stability to ensure the continued delivery of high quality long-term healthcare services throughout New York.

With these issues and constraints serving as a backdrop, I would like to briefly address certain proposals included in the 2014-2015 Executive Budget.

First, there are several proposals that could benefit long-term care residents and their providers of care. For instance, NYSHFA/NYSCAL support the Executive's proposal to eliminate the 2 percent across-the-board provider rate cut effective April 1, 2014.

We also support the Executive's proposal to establish a shared savings dividend program, and to require that the nursing home fee-for-service rate shall be the guaranteed benchmark rate of payment in the absence of a negotiated rate of payment between a nursing home and the Medicaid

managed-care plan.

We also support the $1.2 billion Capital Restructuring Financing Program, the Executive's proposal to increase funding to the VAP program, and to extend for two years, through 2016, the planning period under which the Commissioner of Health would be authorized to phase in 6,000 Assisted Living Program beds.

While these initiatives are beneficial, unfortunately, there are two proposals included within the Executive Budget that eclipse all the benefits of these initiatives and adversely impact New York's long-term-care providers and the individuals we serve.

The first proposal is the Executive Budget initiative to cap case-mix increases for nursing homes at 2 percent for any six-month period prior to January 1st, 2016. In New York's case-mix system, the residents are evaluated based on a level of care they require and then are grouped with other residents based on similar care needs.

Each long-term-care provider is assigned with an average cumulative "case-mix index" by the Department of Health, which represents the resources utilized by the residents, and the facility's payment rate is adjusted by the department based on this index. A provider's case-mix index is adjusted up or down based on changes in direct care provided to residents.

In this system, case-mix increases are presently capped at 5 percent. The state reimburses providers for costs above 5 percent only subsequent to an audit by the Office of the Medicaid Inspector General.

Among the benefits of New York's present case-mix system are that it ensures access to care for high-acuity individuals, those individuals with significant care needs. It enhances the quality of care by linking reimbursement to the acuity of care. And it improves efficiency and contains costs by paying providers prospectively.

From 2006 to 2009, case-mix payments

were frozen at 2006 levels as the state transitioned from the Patient Review Instrument screening methodology to the federally mandated MDS clinical assessment for Medicaid patients.

As a consequence of this freeze, nursing home admissions tended to be directed at care for lower-acuity patients because providers were insufficiently reimbursed for the costs of providing care to high-acuity residents.

Among other things, the 2014-2015 Executive Budget proposal to cap case mix at 2 percent will restrict access to necessary care for New York's frailest residents, as increased nursing and therapy services for those residents will no longer be sufficiently reimbursed.

It will take away the ability for nursing homes to care for the increased needs of high-acuity patients, resulting in increased rehospitalizations and further driving up costs for New York's overall healthcare system.

This proposal contradicts the fundamental principles of having a case-mix system, because the proposal eliminates the incentive to admit high-acuity residents by limiting payment for their increased costs of care.

This proposal would also jeopardize the state's estimated 150 "financially disadvantaged" nursing homes, because these facilities are serving high-acuity populations that have greater care needs than they are being paid to serve.

This proposed 2 percent cap is unwarranted, in that New York's nursing homes continue to provide high-quality care to ever-increasing populations at levels below the Medicaid global spending cap.

Ultimately, this budget proposal contradicts the policy of the state to ensure that healthcare is being provided in the least restrictive setting. As the Department of Health continues to encourage the placement of lower-acuity patients in community-based settings, the Executive's

proposal will have the unintended consequence of increasing the case mix of nursing homes as lower-acuity residents are transitioned out of their facilities and into the community, setting in motion the further degradation of the economic condition of long-term-care providers throughout New York State.

For these reasons, NYSHFA/NYSCAL respectfully requests that this proposal not be included within the 2014-2015 enacted budget.

The second and equal area of significant concern for long-term-care providers throughout New York State is the Executive Budget proposal to mandate so-called standard rates of compensation. The 2014-2015 Executive Budget once again proposes to mandate that managed-care contracts with nursing homes require providers to pay prevailing wages to all nursing home employees throughout the state.

By compelling the payment of standard wage rates in a healthcare environment where

the state has imposed a strict Medicaid global spending cap and has eliminated the trend factor for inflation, this unfunded mandate would negatively impact the quality of care by forcing providers to reduce staff and the hours they work to meet the wage mandate and stay below the global spending cap requirements.

There are significant financial and human capital costs associated with wage mandate initiatives, as evidenced by the home care worker wage parity law. Moreover, there is no provision in the Executive Budget to fund, offset, or otherwise protect nursing homes from the increased costs associated with establishing an across-the-board statewide prevailing wage law for New York's long-term care providers.

Additionally, this proposal would limit patient access as a consequence of its requirement that a provider deemed out of compliance could be prohibited from accepting new admissions.

It is critical to note that in

establishing a benchmark rate for reimbursing nursing homes -- which would be a fee-for-service cost of a provider -- the 2014-2015 Executive Budget safeguards long-term-care employees by incorporating the cost of labor for nursing homes in the benchmark rate, thereby ensuring that wages will not be reduced for providers to compete in a managed care environment. Through the establishment of a benchmark rate, the Executive Budget proposal eliminates any so-called "race to the bottom" argument, and that managed long-term-care plans will only contract with those providers with the lowest labor costs.

For these and other reasons, NYSHFA/NYSCAL respectfully requests that the Legislature reject this unfunded mandate that threatens both consumer access and the high quality of long-term care in New York.

In conclusion, the 2014-2015 Executive Budget contains several positive initiatives that will be far eclipsed by the detrimental patient care and cost

implications associated with the 2 percent patient-case-mix cap and the unfunded standard wage mandate.

There are many expenditures in state government that lend themselves to being capped at a 2 percent level to achieve budget surplus savings. However, capping access to long-term care for the neediest New Yorkers is no way to secure such a savings. Moreover, needlessly mandating prevailing wage rates without providing the necessary funding in a state where Medicaid reimbursement rates fail to sustain the cost of providing care will force providers to reduce direct care staff and the hours they work, which will decrease overall access and adversely impact the high quality of long-term care.

As always, the New York State Health Facilities Association and the New York State Center for Assisted Living will continue to work together with the Governor, the Legislature and all affected constituencies to ensure the continued

delivery of high-quality, effective long-term healthcare services throughout New York. Thank you.

CHAIRMAN FARRELL: Thank you.

CHAIRMAN DeFRANCISCO: Thank you very much.

MR. HANSE: Thank you.

CHAIRMAN DeFRANCISCO: The next speaker is James Clyne, Jr., president and CEO of Leading Edge of New York.

On deck is Kevin Finnegan. And if Mr. Finnegan could move down -- is that Mr. Finnegan? All right. That's a great policy. Move down when you're on deck.

Thank you. You're on.

MR. CLYNE: Thank you. We have extensive testimony, which I will save everybody from reading and just touch on the highlights.

The first is a concern about the global cap and the fact that not all the dollars are necessary in the global cap in order to catch all of the dollars that are in the system. There is some opportunity

there, as other speakers have pointed out, that the ability to have shared savings is something that would really benefit the long-term-care system.

We're very supportive of the capital program but have a couple of suggestions. One, it should be able to fund IT in long-term care. IT is greatly underfunded; we're probably five to 10 years behind the acute care system.

We also believe, in order to reshape the long-term-care system, the capital should be able to be used for assisted living, which is the next step down from nursing home care.

The next area I wanted to touch on is a new mandate by the state, which is the uniform assessment. It's a decent tool, it's creating a uniform assessment for all the levels of long-term care, but it takes three or four times as long to do. There's also tremendous redundancies in the review, where seniors are going to have to be reviewed and reviewed and reviewed, unless

we can work out some of the issues with who has the primary responsibility for doing the review.

Our recommendation is that managed long-term-care plans and the providers should both be reimbursed for this extra expense.

Finally, I want to talk on a couple of the wage issues, both the wage parity, which we also believe is underfunded, that the exact dollar amount -- we haven't come up with a number yet, but it appears to us that the dollars put in for wage parity, and we're glad that some was put in, don't actually meet the true needs of the managed long-term-care plans, and then it's not going to filter down to the providers who have this mandate to provide the wages.

Which makes us skeptical of the standard wage mandate. We were supportive of wage parity because it was always said that it was going to be fully funded, and now here we sit concerned that there could be hundreds of millions of dollars that are

not included that are needed to support this wage. So we are equally skeptical of creating a new mandate for a standard wage, particularly since we have no idea what the wage is going to be, who it will affect, and how much it will drive up wages.

We are sympathetic to the concern that there not be a race to the bottom, but unless there's funding for the standard wage, we have some real questions about it.

The last two things I want to touch on are the case-mix cap. The case-mix cap is particularly perverse if you think about it this way. The Executive's position is they want to get people out of hospitals and move them to nursing homes because we can do rehab cheaper. At the same time, we are trying to push out lower-end elderly people to get services at home if they don't need skilled nursing services.

So if we are successful in those two policy goals, then we will be punished by capping case mix at 2 percent. The case mix will naturally go up if we are taking

higher-cost people from the hospitals and discharging lower-cost people to the community. So we will have successfully completed the department's proposal, but we will be penalized for it. That doesn't seem to make a lot of sense to us.

The last piece I just wanted to touch on -- it's not actually before this committee, but it's something that's come up in healthcare a lot now, and the department has done a fantastic job of pushing the idea that housing is healthcare, that there is a huge connection between seniors that get unnecessarily stuck in an institutional setting because they lack the housing.

The Governor has put in a number of housing proposals on the housing side, and the only thing we're asking is that some of that money be directed at seniors so that we can keep them out of nursing homes and assisted living and keep them in the community.

And with that, I'd be happy to take a question.

CHAIRMAN DeFRANCISCO: Thank you very much, and thanks for the brevity. We will definitely read this carefully. And you get points for brevity.

MR. CLYNE: Thank you.

CHAIRMAN FARRELL: Thank you.

CHAIRMAN DeFRANCISCO: No question about it.

(Laughter.)

CHAIRMAN DeFRANCISCO: Kevin Finnegan, political director, SEIU 1199.

And Paul Macielak is on deck.

MR. FINNEGAN: Good afternoon, and thank you for having me here today. I appreciate the opportunity.

I've submitted some written testimony, which I will not read, but I'll just go right into the meat of things and touch on the areas that others have touched on already today.

One of the hallmarks of the Medicaid Redesign Team reforms has been the effort to provide care management for all by enrolling previously excluded populations into managed

care plans. Our union has worked closely with the Health Department and the healthcare industry over the past three years to help implement those provisions for those receiving home health aide services and personal care.

While the transformation hasn't been perfectly smooth, it's avoided significant disruptions in care and services. This has been because of the protections put in place by the Legislature and the Health Department, in particular the wage parity law, which will be fully implemented this March 1st. It's ensured that workers could continue to serve their clients in different home care programs with different wage and benefit structures were integrated into managed care.

And the law is helping achieve other goals of reform by reducing administrative costs, increasing the quality of services through retention of experienced home care aides. This year, those in need of residential nursing home services will be

required to join managed care plans.

In his budget proposal, the Governor has proposed quality standard language to ensure that resources are available to retain a qualified staff to care for nursing home residents during this transition. We are here to testify in strong support of this provision. Without it, nursing home rates could see a race to the bottom on cost and quality in the competition for contracts with managed-care companies. With quality standards in place, nursing homes can still compete on efficiency and on quality of care, but managed-care companies will not be permitted to drive rates below what is currently spent on staffing.

To be clear, this would not raise wages for an underpaid sector of the workforce. It is designed to ensure that wages cannot be driven down from current levels, raising staff turnover and reducing the quality of care. We do not believe there's any budget implications to this proposal.

And finally, I just want to speak briefly in support of the Governor's request for capital funding, given that the feds have indicated that there won't be any capital funding in the waiver, if the waiver ever happens.

Thank you. And thanks for your time. And if you have any questions, I'm here.

CHAIRMAN DeFRANCISCO: Senator Savino.

SENATOR SAVINO: Thank you, Kevin. Good to see you.

I think that final point you made about the nursing home wage, there seems to be a lot of confusion there, some thinking on the part of certainly the nursing homes and others that this is going to be a tremendous burden on the nursing homes.

But I heard you say that we're not really establishing a higher wage, I think we're starting at a particular level that's already currently part of the industry; is that --

MR. FINNEGAN: The concept is to set

the current contract wages as a floor --

SENATOR SAVINO: Thank you.

MR. FINNEGAN: -- that unlike the home care, which set the living wage as a goal for a whole sector, there was a lot of personal care workers who were getting a living wage downstate, but home health aides were not. And under the home care legislation, it brought up the wages of those who were providing the home health aide services to the living wage.

This proposal essentially doesn't raise any wages at all. It doesn't affect collective bargaining at all, except that it sets what the current prevailing wage essentially is in an area as a floor so that nursing home owners don't underbid themselves and their costs in order to get contracts with managed-care companies and then come back to the union and ask for wage cuts.

SENATOR SAVINO: And it takes into consideration the area wage --

MR. FINNEGAN: Yes. There's I think

17 different regions that the Health Department has set up, and they would set the wage for each one of those regions, because wages vary quite a bit regionally.

SENATOR SAVINO: So I guess the tremendous fear for an upstate nursing home that somehow they'll be forced to pay New York City wages is really unfounded?

MR. FINNEGAN: No, it's really designed to not cost nursing homes anything. There's going to be some outliers where that's not the case, there's going to be a lot of homes that are paying more than what the floor will be, but it's not -- we're not coming to the Legislature to avoid our obligations under collective bargaining and then to bargain our own wages.

It really is going to be -- it's designed and we'll work as closely with the industry as we can, and the Health Department, to make sure that, you know, it doesn't cost anybody anything.

SENATOR SAVINO: Thank you for that explanation.

CHAIRMAN DeFRANCISCO: Senator Smith.

SENATOR SMITH: Thank you for asking, Mr. Chairman.

Good afternoon, Kevin, good to see you.

MR. FINNEGAN: Good afternoon.

SENATOR SMITH: You know the challenge that we have in Southeast Queens better than most. In terms of hospitals, I mean, they're closing, obviously -- I was talking to Commissioner Shah this morning; you're in a fight, just like we are. Do you have any thoughts on what else we can do? I mean, beyond supporting the Governor's capital project. But, you know, in Southeast Queens we've lost three or four hospitals.

MR. FINNEGAN: I do think supporting the Governor's capital budget proposal is very important. And I agree with the Governor that federal waiver money will help the situation greatly.

We're going to have to make some adjustments. I'm not sure -- Southeast

Queens actually doesn't have enough hospital beds --

SENATOR SMITH: Right.

MR. FINNEGAN: Where we're seeing the real turmoil is in management problems, I think, more than anything else, which are going to be worked out.

Brooklyn, on the other hand, while management problems probably started the issues with a couple of hospitals, we have a much more severe situation that I think the federal waiver money will help those hospitals adjust to the changing market going forward.

SENATOR SMITH: Okay. Thank you. Thank you, Mr. Chairman.

SENATOR SAVINO: Thank you, Kevin.

MR. FINNEGAN: Thank you.

CHAIRMAN DeFRANCISCO: Thank you very much.

Paul Macielak, president and CEO of New York Health Plan Association.

On deck, Joanne Cunningham.

MR. MACIELAK: Senators, Assemblymen,

I'm Paul Macielak, president of HPA. Thank you very much for the opportunity to testify. The hour is late, so in the interest of brevity I will keep it short.

HPA is generally supportive of the Executive Budget proposal for health and Medicaid as it applies to health plans. And why not? There's no new taxes in the budget proposal, unlike some prior years. Now, that's not to say we're not paying a lot in taxes today. The HCRA assessments, you know, are collecting over $5 billion, and there are some new ACA/Obamacare taxes that are being imposed, including on the Medicaid program. But we'd like to just have you keep it that way, that there are no new taxes.

To that end, we're also pleased that the Executive proposal does have exchange sustainability addressed out of existing HCRA tax revenues. And we view that as positive, as compared to what's occurred in other states, where additional fees and assessments have been imposed on health

plans, which have added to cost of premium.

The RHIO funding -- local funding for IT collaboratives -- whether it's in Syracuse, Buffalo, the Capital Region, has some state financing which we think the plans are supportive of. And like some prior speakers, we also note that the budget does not include the 2 percent across-the-board cut. To all of that, we are very happy and supportive of.

Now, we have a few concerns I'd like to bring to your attention. The first is, on the global cap, Senator Hannon, as you brought up, the need to really look at the cap in terms of what is under the cap and what's not. Our concern with things like the living wage -- and home care is an example that, we are told, is under the global cap. At the dollar amount, it certainly raises concerns as to whether we're going to pierce the cap as a result.

And while we heard testimony about the nursing home payment rate not having a fiscal -- I think there is concern certainly

from the provider and the plan side that there is a fiscal attributable to it, and we're concerned about whether that too is intended to be included under the global cap.

The global cap this year does look to create a dividend. Which works if, you know, the money is generated and can be passed back out to those that contributed to its savings. Our concern is that the proposal starts with the basis of saying that up to 50 percent of it can be segregated, put aside for the safety-net providers. And we think that may, in fact, reward some inefficient players who have not contributed to those savings.

We also have a concern about the living wage for home care, which I know Christy Johnston raised in her testimony, as well as two other speakers. From our analysis of it, the government is looking to fund about half or a little bit more than half of the cost of that proposal.

And that's sort of a government

promise to those healthcare workers from a year or two ago, which was promised to be funded at 100 percent; we're now told that the number is like $300 million, $350 million. But from the calculations provided us, that only pays for about half of the living wage. The other half, we're told, we're supposed to generate between the plans and the home care providers through efficiencies.

Home care providers are supposed to take down their admin costs, we're supposed to contract that with them for lower admin costs, and generate that for additional savings. Now, that may work, but I don't think anybody who's at the negotiating table feels that's a given. And from our perspective, together with the providers, it looks like an unfunded mandate.

The final point I want to raise is on the out-of-network proposal that is not in the Medicaid and health budget, it's in the transportation budget. But since it really relates to a lot of what we're talking

about, I'll talk about it now. It's a laudable goal. It would increase transparency by providers and plans for consumers, it would provide some consumer protection in terms of some of the surprise bills that a lot of people run up against and that drive a lot of people into a medical bankruptcy. And it also sets up, from our perspective, a streamlined arbitration to try and get some of this stuff straightened out.

We do have a couple of concerns. We would ask you to consider a couple of tweaks to the proposal. You know, in some cases we think it goes, you know, not far enough, in other cases a little bit too far.

So I'll give you an example. Doctors are called upon to disclose their price, if requested. Now, I don't know about you, but when you're sitting there with one of those hospital gowns on without the back, I don't think that that's the time when you're going to ask your doctor about the price of procedures he's recommending. So while we

know that veterinarians provide pricing, we know plastic surgeons provide pricing, we think doctors, likewise, should have an affirmative duty to provide pricing to not only their patients but to prospective patients as well, who are going to decide whether they're going to go to that doctor before they're sitting in the exam room with that gown on.

So we do agree consumers need both. They need to know how much a plan is going to pay for the procedure, but they also need to know how much the doctor is going to charge.

Second, the out-of-network provisions to create a standardized product. We understand what the intent is behind it. It sets a pay level that I know differs from Senator Hannon's -- it's a little lower, certainly, in the Executive proposal than yours. But I think our concern is we're worried about product price suppression.

Now, we're subject to prior approval of our rates. On this last go-round through

the exchange pricing we know plans went in, asked for a 20 percent rate hike, the department said, Let's split the difference, we'll give you 10 percent. Well, you can operate like that for a year or two, but you can't sustain that kind of pricing going forward in terms of the products.

The individual market -- that was a disaster we're all aware of -- was in part due to the fact that there was price suppression of that product. The utilization and the cost incurred exceeded what the rates were, and so thereby plans were losing money on it, the prices were still higher than people could pay, and it led to a death spiral for that particular product.

The final thing we want to bring to your attention in terms of this out-of-network proposal, there's a little clause that was inserted by the Executive to give the DFS superintendent the power to add other out-of-network products and methods at his discretion. Now, if this current

proposal becomes law, I assume it's going to come after we negotiate with the doctors and the providers and the consumers to try and come to some agreement, you the Legislature will have your negotiation with the Executive, and that would become the adopted proposal.

I don't think you would want to have that proposal undercut by a superintendent who then could unilaterally, and in his discretion, create other products that hadn't been contemplated or negotiated, certainly without your input and control. So we'd ask you to, you know, try and put in a check-and-balance on that discretion.

I guess, in conclusion, I would say that, you know, we're supportive of the Executive Budget with a few tweaks. It doesn't contain new taxes, and we'd like you to keep it that way. And finally, if there are any government mandates and commitments, like the living wage, that it be fully funded.

Thank you.

CHAIRMAN DeFRANCISCO: Thank you.

And I don't quite get it either. I've stated this before, I don't understand how people who believe that collective bargaining is sacrosanct in this state could look for the government to start paying for increases, whether it's a living wage or whatever it may be. And it just puts pressure in other areas that I think is pressure that especially some of the healthcare organizations here don't need.

So I understand what you're saying and what the other speakers are saying. Thank you very much.

MR. MACIELAK: Thank you.

CHAIRMAN DeFRANCISCO: While Joanne Cunningham is coming down, I want you to know that's it's official, that Syracuse is number one in both the AP and the USA polls, garnering every single first-place vote. Secondly, however, they play Notre Dame at 7:00 p.m., and that all could change in a matter of hours.

(Laughter.)

CHAIRMAN DeFRANCISCO: And I'd like to watch it.

SENATOR HANNON: I presume that's basketball.

CHAIRMAN DeFRANCISCO: That's basketball, yes.

Joanne Cunningham.

And Liz Dears-Kent is next.

MS. CUNNINGHAM: Thank you very much for the opportunity to testify, and I will be brief.

And I applaud your enthusiasm for Syracuse and share your desire to watch the game later on.

CHAIRMAN DeFRANCISCO: Thank you.

(Laughter.)

MS. CUNNINGHAM: Just a couple of seconds to give you a sense of kind of the big picture, what's been happening with respect to the home care system in New York State.

As you know, the Home Care Association of New York State, we represent certified agencies from one end of the state

to the other, licensed home care agencies, managed long-term-care plans, hospice, as well as the long-term home healthcare programs.

Our members at this stage -- and this is all identified in a report that we provided to you as part of our testimony, which is called New York State of Home Care. But essentially, what has been happening in the home care community over the past few years has been a lot of fiscal challenge and a lot of challenge due to the massive transformation of the home care system in New York State, with most of the home care population moving into managed long-term care and the short-term home care patients having to adapt to the effects of a different payment system.

So we've had a lot of change and challenge over the past few years. And home care providers are really fiscally challenged right now, very fiscally stressed. We're seeing operating margins that are getting worse. Most home care

providers are struggling to meet mandates to stay fiscally afloat, and for that reason we're seeing providers that are very, very fragile and fiscally struggling.

We also, despite this, I think, have some great testimony and success stories of what's been happening in the home care community, with lots of innovation, lots of creative initiatives where home care providers are working with health plans, working with independent physician practices, working with their hospitals.

I mean, they have really risen to the challenge of a more integrated system that focuses on care management. And you would be very pleased to see some of the dynamic home care/hospital partnerships that are evolving in lots of parts of the state. And that's the good news.

Home care providers are really struggling with unfunded mandates. I heard a lot of talk about the living wage mandate. And three years later, here we sit, where providers are on the brink of collapse under

that mandate. And the Executive has included some funding to meet the challenge of that mandate, we support that, but as the prior testimony reveals, it's not enough. It's essentially providing half a loaf and saying, You need to become more efficient providers in order to meet the mandate.

We also -- and it's very appropriate that it's almost Groundhog Day, because I think last year I talked to you about the need for significant regulatory streamlining. And this, to this day, is still the case, and the need is still urgent. And what we have is a mismatch, we have a regulatory system that is anchored to a fee-for-service Medicaid home care program that does not exist.

Instead, we have a managed-care home care program now, with MLTCs as the coordinator of the home care system, and we have a regulatory structure that is anchored in the past. So home care providers are still dragging that ball and chain of regulation along with them in their new

arrangements with health plans.

Last year the Legislature responded to that by creating a regulatory workgroup. And I would say at this point in time -- and the regulatory workgroup, their report to the Legislature is due March 1st, but we have not seen enough urgency and really proactive attention focused on it through the efforts of the workgroup.

So that's really the landscape of what's been happening in the home care community. I would say our priority areas at the association, and these are also articulated in the materials, fall into the bucket of, again, regulatory streamlining. The Legislature can play a very proactive role in helping to transition this system.

Complicating what has been the regulatory mismatch has been also talked about in earlier testimony, with the release of this new DAL last week by the Health Department that really adds further difficulty for the provider community because it's not clear as to some of the

aftereffects, and really how to meet the new costs that the DAL will impose on the system.

So I would ask the Legislature to engage with us and work collaboratively to solve some of that regulatory mismatch. And there's lot of things we can do together.

Related to funding, we are also very, very happy, as prior speakers mentioned, in the fact that the 2 percent cut was eliminated. That will go far in assisting providers like the home health community, who are struggling with fiscal instability, and we applaud that.

We also are concerned by the fact that there was a repeal of the Article 7 language of the workforce recruitment and retention funding for home care. That funding should be moved into a new system and really help in the infrastructure that home care and managed long-term care are working to achieve to deliver high-quality patient care.

We also think it's curious that while

the home care workforce recruitment and retention funding was repealed, the personal care funding was not repealed and the personal care programs were moved entirely into managed care. So where are those dollars? Those dollars could be used to bolster a struggling system, and we would ask the Legislature's help in doing that.

Just a couple more points. One is I also would concur with my colleague Christy Johnston, from HCP, who talked about the need for protections for providers for prompt pay, for mechanisms to make sure that as we transition to this new system that we have provider protections in there related to timely payments. This is the new system for the home care community we need to make sure that we are helping to effectively transition.

I also would call your attention to initiatives that could be funded and more clearly articulated in the budget. There is language for creative innovative new models through the DSRIP funding. We would like

home care to be more clearly identified as a central focus area for funding.

There are lots of interesting innovations that we are working on. The Home Care Association has been working with the Iroquois Health Care Alliance looking at trying to create innovative hospital-home care, payment models, service delivery models that would create interesting types of hospital readmission avoidance programs and better care transition programs to make sure patients are able to stay at home.

Senator Hannon introduced legislation last year that we obviously strongly support. We would look for a mechanism in the budget process to make sure we get that type of legislation and support enacted.

And then, finally, one of the areas that the Legislature has been very active in is identifying home care workers as essential personnel in times of emergency situations -- Hurricane Sandy, upstate New York ice storms -- where there are restricted areas that disallow home care

from entering in. This is a workforce that travels by car, by bus, by subway to see their patients in times of emergencies.

If a home care worker can't get to the home of a patient, the apartment of a patient in times of an emergency, that patient may be placed in an urgent situation and quickly need an emergency room bed, or a different kind of situation. We need to make sure that we are identifying home care workers as essential personnel in those types of situations. The Senate actually unanimously passed legislation last year that would identify home care workers as essential personnel, and we would look for your support in the budget for that.

That's all I have. Go Syracuse! Any questions, I'd be happy to take.

CHAIRMAN DeFRANCISCO: You only saved 25 seconds.

(Laughter.)

MS. CUNNINGHAM: I tried.

(Laughter.)

CHAIRMAN DeFRANCISCO: Any questions?

Okay. Thank you very, very much.

SENATOR HANNON: Thank you very much.

CHAIRMAN DeFRANCISCO: Liz Dears, Medical Society, to be followed by Bryan Ludwig of the Chiropractor's Council. And quite frankly, I'll need an adjustment before the evening is over.

(Laughter.)

SENATOR HANNON: Not if you win.

(Laughter.)

MS. DEARS: Good afternoon. On behalf of MSSNY President Sam Unterricht, an ophthalmologist from Brooklyn, I would like to thank you for offering us this opportunity to present to you today.

I'm only going to talk about three issues. You have our testimony, which touches on many more.

Today's budget is being considered at a time when a number of market forces are threatening the very viability of physician practices. A recent MSSNY survey shows that 65 percent of physicians have indicated that their compensation has decreased

significantly over the past five years; a third of those said that it was very significant. And this is all happening at a time when our overhead costs, including our medical liability premium costs, continue to increase.

This leaves physicians with very little choice but to close their practices, lay off their employees and become employed by hospitals. Until now, physicians have been number-two amongst all industries in the creation of business establishments in New York State and have employed 330,000 individuals.

While we're grateful that the Governor's proposed budget does include, without programmatic change, the Excess Medical Liability Program funded at the historical appropriation, we think this program is essential to retain physicians in New York State, and we need it until such time as we actually are able to get medical liability reform which reduces our premium costs.

We are also grateful that the budget includes language to address the out-of-network issue. We must resolve this issue this year. We need to assure that patients have access to physicians of their choice and that their out-of-network benefit, number one, exists and, number two, will meaningfully pay for the cost of services they receive.

With regard to regulatory reform, which is the third issue I'm going to discuss, I'm actually surprised by others who testified earlier who believe that regulatory reform in the budget is insufficient. We understand and appreciate the public good that are offered by our hospitals to their communities. We think that, rather than leveling up the amount of regulation on healthcare providers, we should actually level down.

We participated in hearings held by the Senate this past fall on regulatory reform and consistently expressed our opposition to applying CON or other

regulatory burdens on physician practices, particularly office-based surgery in urgent care practices. Understanding that the goal of the state is to bend the cost continuum, we're concerned by proposals in the budget that would actually impose additional burdens on physicians in private practice.

In particular, I'm focused on the urgent care and OBS provisions. Our non-Article 28 urgent care is delivered through physician practices which use a business model which addressed a burgeoning patient need to receive care outside of the emergency room when their physician's practice is not typically open.

Urgent care physician practices are, for the most part, small businesses which serve a community's need for healthcare at an economically affordable rate. The provisions in the budget which would require accreditation of these practices are extremely -- will have a significant and financial impact on those practices. I've been on the Joint Commission website; I know

that for a single urgent care practice that sees roughly 10,000 visits a year that that accreditation fee is $10,000 just for one urgent care practice. For a practice that has 120 visits, it's as much as $28,000. On top of which, if they have more than one practice in a community, there are additional charges imposed thereon.

So we're very, very concerned about that, as we are concerned about other provisions in the budget which would require additional reporting by physician office-based surgical practices through their accrediting agencies. We look forward to discussing these issues with you as the budget discussions ensue.

SENATOR HANNON: Great.

CHAIRMAN DeFRANCISCO: Thank you. Appreciate it very much.

MS. DEARS: And I also support Syracuse.

CHAIRMAN DeFRANCISCO: Well, good.

MS. DEARS: Thank you.

CHAIRMAN DeFRANCISCO: The next

speaker is Bryan Ludwig, New York Chiropractic Council, followed by Susan Mitnick, New York State Nurses Association.

DR. LUDWIG: Good afternoon.

I'm not only a volunteer, as district president for the New York Chiropractic Council, I'm also a practicing doctor of chiropractic in Schoharie County. And I understand last year you asked for an adjustment, and this year you asked for an adjustment, and I am quite good.

CHAIRMAN DeFRANCISCO: Okay. All right.

(Laughter.)

CHAIRMAN DeFRANCISCO: I may take you up on it this year.

DR. LUDWIG: The New York Chiropractic Council's mission is to direct people to the realization that healing comes from within each of us, and ultimately promoting health and wellness is going to be superior to treating disease. And our purpose is to promote this basic philosophy, science and art, as well as to protect

chiropractors in New York State.

I'm glad that we've had a couple of our members on the health exchanges, Dr. Robert Browne and Dr. John LaMonica.

Last year I sat here and I had the privilege of testifying before you, and I listened to the testimonies of many other caring, effective organizations, and there was a lot of concerns. And I kept thinking, how could we solve as well as work within a budget? I mean, across the board people will say, okay, we need more funding, pharmacists are saying, jeez, I'm having trouble selling drugs, it's set at a certain price, staying in business, need more beds, hospitals need to be able to fix infrastructure. How would it be better if there were less sick people and we spent less on it, it would be more --

CHAIRMAN DeFRANCISCO: Preventative care.

DR. LUDWIG: Absolutely. And by "prevention," a lot of -- that's a buzz word. We say "prevention," so we might

think, oh, let's do this blood test for prostate cancer, you know. And I've had a lot of discussions with others in my profession, that's not prevention. The disease is already there, so you haven't prevented it. You found it early, but you didn't prevent it.

So I submitted to you, Senator, a very large packet of many, many studies, 140 pages. We didn't kill all the trees to get 40 copies of that, so one of those I wanted to go over. Because it seems just common sense, you know, keep people well and there's less need for funding to treat the consequences of poor health.

So this one study in Chicago, Illinois, in 1999, for seven years they did this. They wanted to test -- I'm going to tell a little story, and then we'll give you the punch line. For seven years they wanted to test the effectiveness of one drug versus another kind of treatment. What they did over seven years -- and just looking at in-hospital admissions, they decreased by

60 percent. I guess there were fewer sick people. There were 59 percent less hospital days, there were 62 percent less outpatient surgeries and procedures, and this insurance company spent 85 percent less on their pharmaceutical costs.

Now, we're not talking 1, 2 percent, you know, something that in a study you can statistically, you know, manage or massage to make it look good. These are huge numbers.

So I went back and I looked at -- the earliest year I could look at was 2012, for the New York State health and Medicaid budget. I got that online, and on three line items -- inpatient, hospital outpatient, drugs and surgery -- we spent $7 billion last year.

So for these three line items, if we follow the lead of this insurance company -- Alternative Medicine, Inc., was their name -- we could save the budget as much as $4.5 billion. Yeah. So I'll say it again, it could save us $4.5 billion.

And I didn't want to just sit here and say, Hey, you know, prevention is great, we should do it. Here's something that has taken the lead and has done it. So I know you really know -- what's the -- what did they do? They just switched one drug for a Treatment B? Well, Treatment B, it wasn't a drug, it was chiropractic care.

So they had chiropractors that were managing patients. And they could call and say, Hello, Mr. Medical Doctor, I have this case I had some advice on.

So the result of all of this was less drugs, less surgery and less procedures. Not because they didn't need it; they were healthier.

So New York Chiropractic Council would like New York State to know it's a simple fact, when people become healthy, they no longer need drugs, they no longer need surgery. And when sick people become well, our budget is balanced.

I saw some big eyes up there. I don't know if you had any questions for me.

CHAIRMAN DeFRANCISCO: No, they just -- big eyes thinking maybe you're done.

(Laughter.)

CHAIRMAN DeFRANCISCO: Not that what you said was not important, I just caught the pause.

DR. LUDWIG: I understand.

CHAIRMAN DeFRANCISCO: Okay. No, I appreciate that.

And no one has any questions, correct?

DR. LUDWIG: We look forward to being a resource. If you have questions, I'm happy to --

CHAIRMAN DeFRANCISCO: I appreciate that, and I remember the report. But thank you.

And the next speaker is Susan Mitnick of the New York State Nurses Association, followed by Mary Sienkiewicz.

MS. MITNICK: Good afternoon.

My name is Susan Mitnick. I'm here today on behalf of the New York State Nurses Association. As the leading union for

registered nurses, NYSNA takes an active role in protecting the rights of nurses and advocating for patients.

Thank you for still being here at this late hour this afternoon. We have submitted written testimony. I'll try to condense it as much as possible, but I hope that you'll take an opportunity to look at it, particularly our comments regarding the healthcare crisis in Brooklyn.

NYSNA welcomes the $1.2 billion in Capital Restructuring Financing Program. We're concerned, however, that the $200 million per year is not sufficient to meet the actual needs of hospitals and other providers throughout the State. Inclusion of other types of providers will also dilute the impact of this funding strength. We urge the Legislature to consider additional funding sources to increase the amount available in this program.

NYSNA also supports funding to establish Regional Health Improvement Collaboratives. We believe, however, that

as proposed, these bodies will be largely consultative and not provide meaningful power and authority to local communities. We urge the Legislature to consider modifications of the RHICs to provide a more concrete and enhanced level of authority and provide real decision-making power to local communities.

NYSNA is particularly concerned by the proposal to establish a pilot program to allow for-profit private equity investors to directly own and control hospitals in New York. The proposals will allow five such entities to operate in the state, provided that they are not publicly traded.

NYSNA strongly opposes any measures that would open the door to for-profit control and operation of our hospitals. We're particularly opposed to the private equity investment model, which is based on a short-term investment model that is often accomplished by means of high levels of debt leveraging, high transaction management and consulting fees, and the stripping of real

estate and other assets.

We believe this is not a viable solution to the problem of access to capital and will only exacerbate the problems currently faced by vital access and safety-net providers. We respectfully ask the Legislature to reject this proposal in its entirety.

In a similar vein, NYSNA opposes the operation of limited service clinics by for-profit enterprises that are primarily focused on generating revenue from retail and pharmaceutical sales. We understand the need for healthcare facilities that provide basic minor healthcare services, but believe they should be integrated into the local healthcare delivery networks and should not be operated on a for-profit basis.

Continuing with the proposals for ambulatory care that are in the budget, we welcome the effort to regulate urgent care centers but believe that they should be subject to full CON review, with particular focus on the need for such services in the

community and the impact of their expansion on existing safety-net hospitals and other Article 28 providers.

We request the Legislature to tighten the level of regulation of urgent care providers and subject them to full CON review.

NYSNA further believes that the proposed expansion of regulations for office-based surgery and anesthesia do not go far enough to protect patients. We believe there should be a level playing field with Article 28 providers and that uniform rules and standards regarding quality and staffing apply to everyone.

Lastly, we oppose the relaxation or elimination of Certificate of Need standards. The CON process plays a critical role in regulating the allocation of healthcare resources and offers often the only opportunity for local communities to have a say in the workings of the healthcare system. We therefore oppose the proposals in the budget that would eliminate "public

need" review, loosen restrictions on adult home, home care, long-term care and other specialty providers, and reduce the lookback period. We urge the Legislature to reject these attempts to loosen the applicability of CON review.

And the rest is in our comments.

CHAIRMAN DeFRANCISCO: Thank you very much. I appreciate it.

(Discussion off the record.)

CHAIRMAN DeFRANCISCO: Next, Mary Sienkiewicz, and Elizabeth Lasky is on deck.

MS. SIENKIEWICZ: Thank you very much for the opportunity to testify today.

My name is Mary Sienkiewicz. I'm director of the New York State Area Health Education Center System, commonly referred to as AHEC.

While I'm here alone today, I'm representing the 26,000 students that we worked with last year -- middle school, high school, college students -- and health professionals and communities. I'm also representing the nine centers and three

regional offices and the statewide office that work with these students from pipeline to practice.

The New York State AHEC System is focused on recruiting and training the next generation of health professionals, and retaining current providers to work in underserved rural and urban communities. We strive to make sure that the health professions workforce reflects the diversity of the State. I'd like to highlight three stories that will illustrate our work in recruitment, training and retention.

At the beginning of the pipeline, we work with middle school and high school and college students with career exploration opportunities. Last year we worked with 12,000 students. One such student, Ariana Aquino, came to the Manhattan-Staten Island AHEC as a student at Washington Irving High School. She participated in three MSI AHEC programs, each a long-term placement in a health or community agency and mentoring by health professionals. Those experiences

deepened Ariana's desire to work in an underserved area and allowed her to focus on the health challenges in her Washington Heights community.

Ariana recently graduated from City College and is applying to physician assistant programs. Once trained, she plans to practice in Washington Heights.

At the middle of the pipeline, during their education and once their training is completed, AHECs can connect health professionals to the areas that need them most. And the example I'll give here is a rural Ellenville, New York, example that now has a brand-new physician in Dr. Kristina Ursitti. As a family medicine resident, she was stationed in a medically underserved community and was linked with our Catskill Hudson AHEC's HealthMatch program, a community-based recruitment and retention program. This is an interesting program because it was created with state HEAL funding and has since empowered a local council of healthcare, business and

government leaders to raise funds to recruit providers.

In this case, HealthMatch and its partners provided Dr. Ursitti with down payment assistance so that she could purchase a home in the area, in which she has pledged to practice in the area for five years. HealthMatch is a great example of how an AHEC spearheading a community effort improved access to primary care.

The next step, I guess, really isn't the end of the pipeline, because as anyone working in healthcare knows, training never ends. Last year the New York State AHEC System trained almost 11,000 providers at more than 400 continuing education sessions. And the example I'll share here is our partnership with the U.S. Department of Health and Human Services on a Veterans Behavioral Health Initiative.

Four of our AHECs trained primary care providers to recognize behavioral health issues confronting military members and their families. And this is important

because approximately half of veterans receive healthcare from community-based providers rather than at the VA. As a result of AHEC trainings, providers demonstrated an increase in knowledge and intent to improve practice with regard to their care of service members, veterans and families.

AHEC programs are as diverse as the areas that they serve. Other examples from other areas in the state are included in the testimony, and also our annual report.

A strength of the New York State AHEC system is our partnerships. Last year we totaled well over 1,000 linkages that connect the supply side of the health workforce -- secondary schools and academic institutions -- with the demand side of the workforce: healthcare employers and communities. We're proud of our long-standing partnership with the Department of Health, and that AHEC programs are aligned with Doctors Across New York, Medicaid Redesign, Health Workforce

retraining and Oral Health Workforce initiatives.

As successful as the New York State AHEC system is, I know that legislators must also consider the cost of continued support. Let me say that AHEC is a sound investment. Every state dollar invested in the New York State AHEC system leverages more than $2 in federal, community and other funding.

For 2013-2014, we were awarded just over $2 million in state funding. This is a 15 percent decrease from the $2.5 million approved by the Governor and Legislature in fiscal year 2010-2011. As a result, all of our AHEC offices have made staff cuts, which hampered our ability to run programs at full capacity.

I think you will all agree that the need for primary care professionals has only grown in the last three years, especially given the needs of our most vulnerable populations severely impacted by the economic downturn. At the same time, we all witnessed a health system transformation

with the advent of health insurance mandate and the launch of the New York State Health Marketplace, which is insuring many of our neighbors for the first time.

This year we must respectfully request a greater state investment than the $2,077,000 currently included in the Governor's budget. Our budget request is $2.5 million, which restores previous cuts. We are keenly aware of the budgetary challenges facing our state. We are just as aware of the shortages of primary care providers in underserved communities, and therefore must advocate for adequate funding to sustain our efforts to grow our own health workforce. Since healthcare is a major driver in local and regional economic development, our ability to recruit and help train health professionals is an integral part of a healthy local, regional and statewide economy.

Thank you for this opportunity and your continuing support. Attached to my testimony is the most recent annual report

that we submitted to Commissioner Shah that details our activities across all of our nine centers, three regional offices and the statewide office. And thank you again.

CHAIRMAN DeFRANCISCO: Thank you very much.

In lieu of Elizabeth Lasky, we have Tracy Russell, who is going to testify for the Pharmacists Society of the State of New York. And I believe Kathy Bryant is going to appear jointly, she's with Chain Pharmacies. And they have common concerns.

MS. BRYANT: Yes, we do.

CHAIRMAN DeFRANCISCO: And want us to pay attention, correct?

MS. RUSSELL: That's right.

MS. BRYANT: Correct.

CHAIRMAN DeFRANCISCO: Okay.

MS. RUSSELL: First, I want to thank you, Senators, Assemblymembers and staff, for your attention today. My name is Tracy Russell, and I'm the executive director of the Pharmacists Society of the State of New York. I'm fairly new, since August of

2013, so I'm going to give you as much background as I have here.

PSSNY members represents pharmacists in New York from all sectors of pharmacy and from all across the state from every corner. So when we speak to you, we're speaking to you on behalf of all of the organizations that represent pharmacists in the State of New York.

As I'm sure you're very aware, pharmacists have been ranked as one of the top two most trusted professionals in healthcare, consistently in one and two spots, sharing that with nurses throughout the years. And I know that you guys know this, because you've supported pharmacy over the years, and we very much appreciate all of your support.

In 2013, the Department of Health required every pharmacy enrolled as a Medicaid provider to complete two extensive surveys, the cost surveys, that are based on its analysis of the survey results. The department plans to implement a new pharmacy

reimbursement formula as early as April of 2014.

Today we are here to ask you to please remove from that final budget the Commissioner's authority to change dispensing fees and to reimburse for medications using the average acquisition cost as the new benchmark. We make this request based on the inconsistent policies of the past and on the very flawed nature of the methodologies used in obtaining the results of the recent survey.

The concerns are outlined in the letters that are provided to you in my testimony, and these letters are from all organizations of all areas of pharmacy in collaboration, both on the state level and on the national level. The concerns, while they're in detail in those letters, I'm going to briefly go over some of the more blatant flaws in that survey.

In the methodologies that were used to obtain results, the inclusion of rebates. Across the board, rebates were included.

However, this is not real life. Rebates are not guaranteed, and are never across the board.

Medicaid fee-for-service patients are not required to pay the copay of $3 for brand and a $1 for generics. It's optional. This was not a consideration in the survey results. And about 50 percent of the time the patients do not pay that copay, the pharmacy has to take that cost on themselves.

Only 61 percent of the pharmacies in the state were included in this mandatory survey. There are many pharmacies that were given the approval to not complete the survey because they were dealing with the cleanup from Hurricane Sandy and they were working with individuals in that area and it would have been a burden on them to comply.

Many of these pharmacies are in areas where there's high population and high impact. If these survey results are adopted, it will become a benchmark for other payers. It will be devastating for

community pharmacies and for the patients that they serve, as there will be an impact on access to care.

To respond to Commissioner Shah's comments regarding the taxpayers should pay a fair price and "not be ripped off." First, aside from taking offense to that, that the pharmacists are ripping off taxpayers, we do not disagree that the state should pay a fair price and not be ripped off. We agree 100 percent.

We also agree that a fair number should be determined by a fair methodology. As previously stated, the survey results are flawed. The Department of Health indicated that some outliers were thrown out, but not all the outliers. And we have yet to be able to get a response as to which outliers were thrown out. The survey results, in the words of the Department of Health, were "smoothed" and "cleansed" to get certain -- and the results were obtained.

The Commissioner indicated the average acquisition cost is used in most

states, that this method is used in most states. We have looked at the Medicaid surveys across the nation and can only find six states where the average acquisition cost is actually used. And in these states, where there's not an average acquisition cost for a drug, they use the wholesaler acquisition cost, known as WAC.

Those six states, I want to point out, are Alabama, Colorado, Idaho, Iowa, Louisiana and Oregon. And I mention those states because in the Department of Health survey results, believe it or not, it is more expensive to fill a drug in any of those states than it is in New York. It is more expensive to do business in Alabama than it is in New York.

Now, the last that I checked -- and I do have several relatives in some of those states -- it was a lot more expensive to do business in New York than it was in Alabama, Louisiana, Idaho, Colorado, Oregon or Iowa. Furthermore, in those states that I mentioned, pharmacy reimbursement is fair

and acceptable by the providers and the departments, and they continue to assure access to care.

The survey results of the New York AAC are not average, as implied. In an average outcome, there are winners and losers, by nature of being average. The outcome of these results, everyone's a loser, because the results are less than average.

The Commissioner indicated that medications are constantly increasing in expense. No one knows that better than the pharmacists. Someone has to buy those drugs, keep them on the shelf and have them available for when the patients come and need them. In many situations, if the results were implemented as the Department of Health would like to see -- and we could provide you with examples -- the pharmacists will lose money. They will not be reimbursed even the cost of the drug. How long can you stay in business when you do something like that?

And of course the pharmacies continue to provide services that are not compensated for, so it's not just a commodity, it's a service as well. If New York's AAC proposal is allowed to take effect, it will be a tremendous harm to pharmacy businesses across the state.

Commissioner Shah also made comments this morning surrounding HIV patients and their care, and the goal is to get patients on therapy and keep them on therapy. Pharmacists do this every day with patients across various disease states, not just HIV patients. Through medication therapy management, which is mandatory in Medicare Part D and has proven positive outcomes, pharmacists do this with all disease states -- diabetes, hypertension -- and they're not reimbursed for their service.

Pharmacists have the training and ability to provide more preventative care, and that my colleague will elaborate on. These services are more cost-effective and will result in cost savings through avoiding

drug interactions, avoiding unnecessary hospitalization and improving adherence and positive outcomes. It's our suggestion that the Department of Health spend more time on how to capitalize on these issues and less time on how to cut already dwindling reimbursement rates and on unnecessary surveys.

I say unnecessary because the department has made it clear that they plan to move the Medicare fee-for-service patients to Medicaid managed care. So why spend taxpayer dollars on surveys that are not -- the results are not going to be useful over a very short period time?

I'd like to thank you for your time and consideration. And I'll now turn to my colleague, Kathy Bryant, for further explanation.

MS. BRYANT: Good afternoon. My name is Kathy Bryant, and I'm the vice president of pharmacy for Price Chopper Supermarkets. I'm a licensed pharmacist, and I'm an officer of the Chain Pharmacy Association of

New York.

I'd like to take a moment to discuss the realities of where the profession of pharmacy is going and what we are being asked to do in our communities.

I'd like also to comment on the surveys discussed, and the time involved to complete them. The surveys are very time-consuming and labor-intensive. I personally have a staff of 15 employees in my office, and I'm asked to operate 81 pharmacies in our communities. I dedicate one full-time employee for a full week to completing the survey. Most patients are already moved into managed care, and these resources are spent on, in my case, less than 2 percent of my patients that are currently in the fee-for-service program.

As you know, pharmacy practice is moving towards patient-centered services and collaborating with healthcare, health plans and hospitals. We're involved in immunizations and MTM health and wellness programs, services that can truly improve

outcomes and realize health saving costs. Many plans and providers are seeking us out to help them take care of their patients, they like the idea of working with pharmacists who are community-based and who are actually the face of their communities.

I'd like to give you a few examples of what we're currently working on with my pharmacy team at Price Chopper, just to bring it home a little bit. We're working with CDPHP, a local health plan, to provide medication therapy management sessions, because they need us to help them with better outcomes. They're overwhelmed with their patient base, and they just can't get to all of the patients that they need to see. They too are charged with bettering outcomes and decreasing costs.

Just a week ago, we opened two urgent care clinics in two of our Capital Region pharmacies, our supermarkets, with the collaboration of Ellis Hospital. The QuickCare clinics opened to provide more access to our patients in the communities.

We're trying to keep patients out of the emergency room and making that doctor visit part of their normal day, so the supermarket fits in very nicely into that theme.

We're working with Albany Med on an outpatient-based hypertension program aimed at prevention in our communities, with a focus on overall health and wellness. Adding the supermarket pharmacist is very attractive to them, because they see the value in health and wellness and nutrition, including dietitians, et cetera. So as you can see, we work into a lot of nice plans for collaboration with other healthcare providers.

We're working on a readmission program with a local hospital and health plan, the goal being keeping our patients out of our hospitals. Once they're discharged they work with pharmacists, talk about their medications, with a goal of making them and keeping them compliant so that they stay healthy. As you can see, together we're working to provide better

outcomes and reduce healthcare costs.

We are asking for your support for a reimbursement rate that is fair and can support all of these programs that I just described. We need your assistance in driving and expanding these programs. And this will be where true savings and better outcomes will be realized. The possibilities are endless right now for we in pharmacy, and the opportunity is here and now.

Thank you for your time. I'd be happy to take questions.

CHAIRMAN FARRELL: Thank you.

CHAIRMAN DeFRANCISCO: Thank you.

You don't like Dr. Shah's methodology. What do you want in its place?

MS. RUSSELL: The methodologies that were used, we would like for them to first give us a response as to clearly what they were, because everything they've showed us is not correct. And in its place, we would like to go back and look at what the other states are doing with AAC and the WAC.

CHAIRMAN DeFRANCISCO: Can you look at them and just let us know what you think would be a better methodology, so we have something to compare it to?

MS. RUSSELL: We've been waiting for results from the department. And again last Friday we were put off again, that they need to continue to look at them. And so as soon as we get the results and are able to review them --

CHAIRMAN DeFRANCISCO: Okay.

MS. RUSSELL: -- and have communication, we will.

CHAIRMAN DeFRANCISCO: Thank you.

And I have legislation requiring copays to actually be paid. Very novel thought. So I just wanted you to know I understand that, and hopefully we can get something accomplished.

Senator Hannon?

SENATOR HANNON: Let me just echo what Senator DeFrancisco has said.

And to the extent that you can take the computation of WAC, make it

mathematically certain, that would be welcome. Taking out the adjustments and all of that.

MS. RUSSELL: One of our concerns is that the department currently has the authority to enact this beginning April 1st without -- you know, if no one tells them not to.

SENATOR HANNON: Well, that's what happens with annual statutes, you get a chance to change things.

MS. RUSSELL: Okay. Great. Thank you.

CHAIRMAN DeFRANCISCO: Thank you very much.

MS. BRYANT: Thank you.

CHAIRMAN DeFRANCISCO: Thank you.

We've got to move quicker before other legislators show up again.

(Laughter.)

CHAIRMAN DeFRANCISCO: All right. The next speaker is Anthony Caputo, president of the Consumer Directed Personal Assistance Association.

Jo Wiederhorn is next.

MR. O'MALLEY: Hello. Good afternoon. My name is actually Bryan O'Malley. Mr. Caputo regretfully was stuck downstate due to the weather, so he was unable to be here.

CHAIRMAN DeFRANCISCO: It's all right with me, I don't know --

(Laughter.)

MR. O'MALLEY: So I will largely stick to this, because brevity is not my strong suit. But I have redacted it for you, in that interest.

The Consumer Directed Personal Assistance Association of New York State, or CDPAANYS, represents fiscal intermediaries and consumers in the state's Consumer Directed Personal Assistance program. We are that novel organization that is both a provider organization as well as a consumer organization, because within the program, consumers are the providers.

So with that in mind, our analysis took place looking at two particular things.

First, the Governor and the Department of Health filed a state plan amendment to implement the Community First Choice Option late in 2013. The amendment to the state plan allows the state to use CDPA as the base to draw down an additional 6 percent in federal matching funds. When all of the services that qualify are taken into account, an aggressive implementation would allow the state to realize a net revenue increase of $90 million.

Second is the unveiling of the Governor's *Olmstead* plan in about September of last year. The plan details how the state will meet its obligations to allow people with disabilities and seniors the right to live in the least restrictive setting. As part of this, we lauded the Governor for his proposal to remove 10,000 individuals from long-term nursing home placement over the next five years.

And we also applauded the decision to save the state considerable money, draw down the increased federal matching funds and

increase consumers' independence by strengthening the role that CDPA plays in the managed care system.

While some of the goals from CFCO and the *Olmstead* plan will be implemented administratively, we are troubled by how little the budget does to advance either. I think the best way to sum this up, numerous speakers have commented today that in this shared savings proposal, they're not seeing savings. I challenge anyone to look through this budget and find one ounce of revenue that's being redirected back into Consumer Directed Personal Assistance. Specifically, we do benefit from the 2 percent across-the-board cut restoration.

So with that in mind, we do have several proposals to strengthen consumer directives. Primarily, we are calling on the Legislature to fund a $1.35 per hour increase in pay for fiscal intermediaries outside of New York City, and a $1.94 increase for those within the city. These increases account for many things that

the funding detailed earlier to offset the wage parity also account for, such as growth in workers' compensation, that equals approximately 40 percent, and growth in unemployment, that equals 20 percent.

Within New York City, many of the expenses were always funded by HRA so are not actually accounted for within the fiscal intermediary's rate. These were separately funded.

We estimate all of this to cost the state approximately $26 million. With any kind of reasonable implementation of Community First Choice, that would pay for itself. So we are asking for the savings that are generated to be implemented back within our system, to strengthen it and generate further savings.

When the Department of Health issued regulations for Consumer Directed Personal Assistance in 2011, it noted that the program costs $2.16 per hour less than personal care. These savings increase when more costly forms of home care or skilled

nursing are measured. Therefore, even by the conservative measure, this small increase in funding will still make CDPA the most cost efficient service the state offers for community-based long-term care. Without it, the continued viability of the program is in question.

Another threat to the viability of not only CDPA but all community-based long-term care is provisions that lead to the favoritism of institutions, creating *Olmstead* issues by favoring nursing facilities over people's own houses.

First, the budget continues a precedent that has been set as any program moves to managed care; it continues their fee-for-service rate within nursing homes. However, unlike any other service, the nursing home guaranteed rate of payment at fee-for-service rates is guaranteed indefinitely. The budget does not sunset this clause.

This is clearly a -- we hope a mistake. But in the instance that it is not

corrected in the 30-day amendments, we do ask the Legislature to address this. We have no problem with a two-to-three-year extension, as every other industry has enjoyed, but an indefinite extension creates a favoritism to institutions within the system.

Similarly, we are also opposed to the provisions that would require nursing homes to receive from managed-care companies a rate of pay that would allow them to pay what is determined by the Commissioner of Health and Commissioner of Labor to be a living rate of pay. We think this creates *Olmstead* issues as well, in that it will send workers to institutions, creating shortages within the community, and it will, over the long-term, take dollars out of the community to fund these increased payments within the long-term care system.

Unlike some of the nursing home providers that came before you, we actually would support this provision if it were for fiscal intermediaries. I'm not going to

speak on behalf of all community-based providers, but if this were for fiscal intermediaries, we would support it, and we actually are calling on you to give us this protection. We want to avoid this race to the bottom. We want to be able to pay workers. And we view this as another way to address the growing wage gap that exists even within community-based long-term care.

Finally, we are strongly opposed to the Governor's proposal to allow the Commissioner of the Office for Temporary and Disability Assistance to contract with an outside entity to conduct fair hearings. And we encourage the full restoration of due process rights for Medicaid beneficiaries, including the right to a fair hearing without the need to go through managed care plans appeal process, and the right to aid continuing.

The fact is, consumers within CDPA are those who used the most number of hours. They are the ones who are most often faced with cuts to their hours, cuts to their

services, and they're the ones who are most likely to wind up in a nursing home if those services are improperly cut.

What we saw, the Department of Health, in a PowerPoint presentation that was meant for the managed long-term care industry, told us that 75 percent of personal-care-related fair hearings stemming from a managed-care plan were decided in favor of the consumer. Seventy-five percent. Three of four had their hours or services unjustly cut. That results in institutionalizations. One case in Rochester went from 112 hours to 38.

So we need these protections back. This is how we will keep consumers in the community, this is how we will continue to save revenues, by keeping people out of institutions and the state in compliance with Olmstead.

There are a number of other provisions in here that I am going to not discuss today. If you have any questions on any of these, I'm happy to take questions.

CHAIRMAN DeFRANCISCO: Thank you.

Senator Krueger.

SENATOR KRUEGER: Bryan, I appreciate your testimony.

So the Governor's budget is actually proposing privatizing all Medicaid fair hearings or a specific universe of Medicaid fair hearings?

MR. O'MALLEY: The language within the budget allows the Commissioner to contract for the fair hearing process.

SENATOR KRUEGER: In any way, shape or form?

MR. O'MALLEY: That's -- it traditionally said something along the lines of "may appoint the designee" and now it says "may appoint the designee or contract for fair hearing.

SENATOR KRUEGER: So I did not see that when I read the budget, so thank you for highlighting that to me, because I find that extremely disturbing.

The whole concept of fair hearings is to ensure due process when a decision is on

made on someone's behalf when they're receiving government benefits. And I think it's about the last thing in the world we should be privatizing or contracting out.

Second question, explain again to me why you want to be under intermediaries, why you want to be under an intermediary system, I believe is the term you used.

MR. O'MALLEY: We currently operate under a fiscal intermediary system. It's a three-party system. The fiscal intermediary acts in many respects like the HR department for the consumer. You know, the consumer would be in no position to pay their workers up front, so the fiscal intermediary floats that amount of money until the managed long-term-care plan or managed-care plan pays. The fiscal intermediary takes care of taxes, any number of other things.

They also offer a number of support mechanisms for the consumer, be it conflict resolution with a worker or in some instances some do provide voluntary training if the consumer desires their workers to go

through training.

So it's just the way that the system was set up in 1995 when the legislation was passed.

SENATOR KRUEGER: But your testimony was you want to continue in that system.

MR. O'MALLEY: We want to continue in that system. And I represent both the fiscal intermediaries and the consumers.

SENATOR KRUEGER: And somebody -- i.e., the state -- doesn't want a continuation of this model?

MR. O'MALLEY: No, I think everyone wants the continuation of this model. We are advocating for the growth of the Community First Choice Option, which would use this model and grow it to include a -- streamline a number of other services that people are currently receiving, and allow the state to draw down an additional 6 percent of federal matching funds on top of that.

So I think that might be -- you know, that's the change to the system that we're

seeking. You know, currently the Governor is anticipating $19 million. We think that that is an underestimation even on the most conservative of estimates.

We think that, you know, with full implementation, including a Nurse Practice Act amendment, we think that the revenue could be as high as $150 million with a net of $90 million. So we don't understand why this money is being left on the table.

SENATOR KRUEGER: Thank you.

Any other Senators?

CHAIRMAN DeFRANCISCO: Thank you very much.

MR. O'MALLEY: Thank you.

SENATOR KRUEGER: Thank you.

CHAIRMAN DeFRANCISCO: Jo Wiederhorn, of the Associated Medical Schools of New York, followed by Dr. Lawrence Eisenstein.

MS. WIEDERHORN: Good afternoon.

CHAIRMAN DeFRANCISCO: Good afternoon.

MS. WIEDERHORN: I'm Jo Wiederhorn,

president and CEO of the Associated Medical Schools of New York.

Before I begin, I just wanted to say that I too have orange on. Both of my sons went to Syracuse. So does that give me any brownie points?

CHAIRMAN DEFRANCISCO: Very good. That gives you one less minute, because you wasted some time.

(Laughter.)

MS. WIEDERHORN: Uh-oh.

(Laughter.)

MS. WIEDERHORN: I have submitted written testimony for you today, but I think that rather than going through that, there are two fact sheets in the very back of it. And I think that I just would like to review what those two fact sheets are and why they are important to medical education in New York State.

As you know, there are 16 medical schools in the state. And what we all support are the tri-missions of medical schools, which are medical education,

patient care and medical research.

In terms of medical education, we are very focused on training the next physician workforce. We have been supporting diversity programs that do just that since 1985. The programs that are actually on the Diversity in Medicine Fact Sheet, which is the first fact sheet that you should have, those programs have been funded by the Department of Health since 2002 and then through the Executive Budget in 2008. There was a short period there where the Legislature supported them.

And last year, thanks to your support and intervention, these programs were unbundled from the bundled programs that DOH had suggested. And because of that, we were able to continue them. Now, what happened was, though, we were able to continue them with a 5 percent cut.

So what I would like to do is just talk a little bit about these programs. On the front of it, which is the front has the big 93 percent on it, these are our

post-baccalaureate programs. Students who enter these programs have a place waiting for them in the next year's medical school class if they successfully complete the program.

And these are outcome data. And I think you can see by the outcome data that these students do very well.

One of the most important things about these students are that if they are accepted at a medical school anytime that they're in this program, they have to go to the medical school. So these are students that would not have been accepted to medical school other than through this program.

So we have a 93 percent success rate, outcome rate, with our traditional post-bacc program, which takes place at Buffalo. That one has been in existence since 1991. And then we also have a 93 percent success rate with our three master's degree programs. These programs are at three medical schools. They provide master's degrees for the students. And then if they successfully

complete it, they go into medical school with a master's in science already.

So 93 percent of the students went into medical school. The other 7 percent did not meet the requirements for the medical school, but they did end up with a master's. So we feel that that is success in its own right.

The funds that we received from DOH, if you flip the page, also include three other programs, not post-bacc programs. One is a program that pairs juniors and seniors at CCNY with NIH-funded researchers to teach them about research, one is a high school program, and one is a learning resource program at our B.S./M.D. program.

Now, in past years we've also been able to fund three MCAT prep programs at three medical schools. That's the Medical College Admissions Test. And we were able to fund those programs for about three years. This year, because of the budget cuts, we were not allowed to fund them, we didn't have the funds for them. Given that

in the Executive Budget we're funded at the same level going forward, we will not be able to fund them again next year either.

The other thing is that the students in these programs are not allowed to work. We give them their daily living expenses -- this is for the post-bacc programs -- and they not gotten an increase in their yearly stipends. In Buffalo they haven't gotten an increase since 2005, and at our three master's programs they haven't gotten an increase ever.

So these students pay for their rent, they pay for health insurance, they pay for books, they pay for any kind of incidentals out of the stipends that we give them.

So I am once again asking for your help and would like to ask to have our funding restored to our 2008 level. It would be an increase of about $400,000. And this money goes to the students, mainly; this money goes for their stipends.

So that's the first thing that I wanted to draw your attention to. The

second one, the second fact sheet is about biomedical research in New York State.

Now, research is also a part of medical education. Medical schools train physician scientists who then work in laboratories and are able to discover new gene therapies, new biomedical structures, that sort of thing. The things that new lead to new technologies moving forward and now therapeutics moving forward.

On this page I think there are a couple of things that are very important. The funds for biomedical research really maintain the medical schools. The funds for tuition pays for about 2 percent of the cost of medical education.

So if you look at this fact sheet, you'll notice that New York is third in the attainment of funds from NIH. We've been third for a number of years except for during ARRA, when the state agreed to provide matching funds to any federal funds that came into the state, and we then jumped up to number one in terms of funding. But

that was for a very short period of time. We're now back to number three, with about $2 billion worth of funding each year from NIH.

This past year we lost $102 million from NIH due to sequestration and budget cuts. And even though the budget for the coming year has been finalized, those cuts are remaining within the budget and so that $102 million will not be restored. And this is a very important thing as we begin to look at comparing what New York State has been doing in terms of supporting biomedical research as it compares to other states.

The very bottom talks about how New York compares to other states. So you'll notice that in Texas the state made a $3 billion investment, California $3 billion, Massachusetts $1 billion, and New York a $600 million investment.

But the important piece of that is not only the investment but if you look at the job growth since the investment was made, New York really lags behind. New York

really looks quite -- almost pathetic on this chart. Excuse me.

So clearly what we're asking for today is that you look at this and be supportive of and look at the realities of investments in biomedical research.

If you flip the page over, biomedical research in and of itself needs to be paired with incubators, bioscience, new technologies. And that is often funded partly through the state, partly through venture capital firms. So if you look on the left at the pie chart, you'll see that venture capital firms are generally putting money into states where the state has made a large investment. Forty-seven percent of the money goes to California, 12 percent to Massachusetts, 4 percent goes to New York.

The other interesting thing about this is if you look at venture capital firms in New York that support biomedical research, only 9 percent of their money stays in New York. The rest of it goes out to California and Massachusetts. So clearly

something needs to be done about this if we're going to have a strong biomedical science industry in this state.

And then finally, I think the other important piece is that there are now 75,000 bioscience jobs in New York, and those jobs pay about twice as much as other jobs in the private sector.

So again, I would appreciate any support you may have for biomedical research and for our diversity program. So thank you.

CHAIRMAN DeFRANCISCO: Thank you very much.

Dr. Lawrence Eistenstein, New York State Association of County Health Officials. Senator Hannon sends his apologies; he had to run.

(Discussion off the record.)

CHAIRMAN DeFRANCISCO: Thank you. Whenever you're ready.

DR. EISENSTEIN: Thank you, sir.

Good afternoon, everybody, and kind regards from all of the local health

officials across New York State. Special greetings to Chairman DeFrancisco, Chairman Farrell, members of both houses, and a special thank you to my own Senator, Kemp Hannon, who really is a local hero in Nassau County for healthcare for many years.

I'm Dr. Lawrence Eistenstein, commissioner of health for Nassau County. I'm here today serving as president of the New York State Association of County Health Officials, NYSACHO for short. I'm joined by our executive director, Linda Wagner.

Thank you for the opportunity to speak on behalf of our colleagues and all of your constituents about how the 2014-2015 state budget proposal may affect public health at the local level.

Both appropriations for Article 6 public health aid and for categorical public health funding support work that protects the lives and improves the health of the residents in your communities. In most cases, many cases at least, local health departments are sole provider of these

services. The scope of services provided by public health is very broad, varied, but really life-saving in many cases.

In Nassau County, I could tell you on an ordinary day we investigate infectious disease outbreaks and routine cases ranging from HIV to tuberculosis to meningitis or even norovirus. We continue to respond to Hurricane Sandy, helping residents whose homes were destroyed deal with health-related issues such as mold or asbestos as homes are being rebuilt.

We continue, along the same lines, to build our emergency preparedness department. Public health emergency preparedness has proven over and over again to be so important.

We inspect our restaurants, our summer camps and our swimming pools to make sure that our children are safe when they're enjoying recreational activities. And public drinking water and beach water bathing occurs in Nassau and in many other counties on a daily basis. In fact, when

you think about public drinking water, many people take it for granted. They turn on their sink, clean water comes out, and they don't think twice about it. That means the public health officials are doing a great job in making sure the drinking water supply is clean. But don't be mistaken, hundreds of thousands of tests, engineering plan reviews and other work goes into making sure that that water is clean and safe for our residents.

County health departments across the state are working on programs to prevent childhood obesity. Recently in Nassau we established our Community Health Assessment Community Health Improvement Plan as directed by our partners and colleagues at the State Health Department, and obesity and chronic disease was clearly the number-one thing that the community wanted us to help them address.

And across the state we do activities to control smoking, among many others. These activities make New York a safer,

healthier place. This is not just a cornerstone for health, it's a foundation for lower healthcare costs and economic development in our state.

NYSACHO was happy to work with the Legislature and the State Health Department last year to modernize the state's Public Health Law under Article 6. Two new categories were added to the list of mandated core public health services that must be conducted by local health departments: Chronic disease prevention, which is so important because we know obesity and chronic disease is one of the driving factors of the high costs of healthcare across the United States, and public health emergency preparedness. Not just from Hurricane Sandy; we also recently across New York State experienced Hurricane Irene and Lee, and catastrophic flooding occurred not only along the coastal regions of New York City and Long Island but in the Southern Tier and the Northern Catskills and the Adirondacks.

And public health emergency preparedness is so important in making sure that our vulnerable patients who need medical care are able to get that help when the local resources are overwhelmed.

Part of emergency preparedness as well is establishing medical reserve corps of volunteers who come and assist during times of crisis. There's a great partnership between the medical reserve corps from one county to another.

NYSACHO greatly appreciated that the Legislature increased the state aid base grant to help support this work last year. We just want to remind you that the cost for these and other public health services continue to increase. We only ask for your continued fiscal support.

Recently, in December exactly, NYSACHO received an unpleasant surprise when the State Health Department announced their plan to make an administrative cut in the 2013-2014 State Aid to Localities. This announcement came in December, as I stated,

basically after almost all of the counties had finalized and approved the county 2014 budgets. It was too late at that point for county health departments to make adjustments.

The plan relates to the allowance for revenue offset. This is a long-standing formula that reduces the amount of local revenue that a county must subtract from its state aid claims. It allows for indirect expenses such as fringe, for example. We were asked to help the State Health Department decide which local health departments should receive this cut, which ones were not in such fiscal distress that they could take a cut.

We don't believe any county is so fiscally well off that they could afford to take a cut. In fact, if a county is not in fiscal distress, they shouldn't be punished in order to preserve other counties that are. That's the general sentiment of NYSACHO as a whole. We don't believe any counties, after their budgets are prepared

for 2014, are in a position to take this kind of a fiscal cut. Most county health departments have experienced cuts of some kind in the last five years during the downturn in the economy, whether it be layoffs, which happened in numerous counties. I know in my county we are down to doing just mandated services. The fact is any further cuts would drastically, potentially, affect the services that we provide.

To give you perspective, in Nassau County the revenue offset, were we to be found to be a county that would participate in this, would cost us about a half a million dollars, a half a million dollars in the health department's budget that was already established and already is down to just mandated services, following efficiencies and doing everything we can to remain viable and provide the same great level of support that we have for all the years.

These numbers vary by county, but

regardless, small or large, these cuts can be very difficult. And we come to you to say, well -- Senator DeFrancisco asked a speaker earlier, Okay, you don't like something; what is it that you recommend we do about it? Well, we think we'd like to respectfully suggest a 2 percent increase in the state aid reimbursement, from 36 percent to 38 percent. That would make us somewhat whole if we received the expected cut that we've been told is coming. It's our suggestion on how to maintain our services and get through these difficult times.

With the downward trend in state aid claims, this 2 percent rate increase can assure your intent to maintain the capacity for local public health. Given the information we have about claims in 2013, and we do not expect this increase to require an increase in the proposed Article 6 appropriation as a whole.

In other issues, we fully support the New York State Association of Counties, NYSAC, in calling for the integration of the

preschool program for children with disabilities into the state-funded universal pre-K program as part of this year's budget proposal.

I know a lot of talk has gone on today regarding early intervention. NYSACHO's position is we want to see the state's fiscal agent work, we want our children to receive the utmost of care, and we support moving forward with the belief that this model can work.

Regarding the consolidation of local health program funds and pools of funding, we do not have sufficient information yet to have a position because we do not know which programs are in which pools of funding. We believe we can work collaboratively with the State Health Department to get this information and confer with our member local health departments about the impact of consolidation on mandated public health services.

Thank you for the opportunity to provide this input. I know you've had a

long day. We're happy to take questions now or any other time afterwards. And thank you.

CHAIRMAN FARRELL: Thank you very much.

Questions?

SENATOR KRUEGER: Just very quickly, just to synthesize my hearing you.

So counties billed the state less, so the state cut the amount in the budget for county public health, but the reason counties billed the state less was because the match was higher for them to do so, so you're asking for your historical match so that you can draw down the money you really need?

DR. EISENSTEIN: Well, we weren't given an explanation as to why the revenue offset is out of this year's budget. It's new to us, it hasn't happened before. We were just told it was happening.

So our response is we're trying to preserve our function, just present a solution that would preserve our function.

But we can't explain why or where the cuts came from other than we were told it's happening. And we don't know the formula for which counties are considered to be in fiscal distress.

We were told to figure out which counties could absorb the cut, as NYSACHO as a whole. But as an executive board member of NYSACHO, I don't think any of our executive board members felt comfortable saying that another county was fiscally sound and could be cut. None of us believe right now that really any counties are so fiscally sound that we can just cut them, and we don't know the formula, so to speak.

But we're happy to work with the State Health Department collaboratively. We've asked for further guidance and information. This did just happen in December, but our budgets were already in. So this was our chance to bring this up as part of local health department survival, so to speak.

SENATOR KRUEGER: Thank you.

DR. EISENSTEIN: Thank you.

CHAIRMAN FARRELL: Thank you.

Dan Lowenstein, Primary Care Development Corporation.

And then after that, James Lytle, if you can come down to be closer.

MR. LOWENSTEIN: Thank you, Chairman Farrell, Chairman DeFrancisco, members of the Senate and the Assembly. Thanks for hearing our testimony today.

Just to start out, I'm going to paraphrase and kind of go through some key points here, but you have the written testimony.

First of all, about Primary Care Development Corporation, we are a nonprofit corporation whose mission is to expand access to quality primary care in underserved communities. And we do this really in three ways. We provide affordable capital to build the primary care infrastructure; we provide technical assistance to help more primary care operate in the medical home model that provides

greater access to better care; and we provide policy advice to really make sure that we have strong policies at the state level and at the local level that supports a strong primary care environment.

We've done about half a billion dollars' worth of investment over the last 20 years. And we're 20 years old, actually, this year. And it's about a 5-to-1 private/public match. We get private funding, private sources of capital, about 5 for every public dollar raised. Forty-eight hundred jobs have been created from this, and access to care for about 725,000 New York State residents.

A little bit about what's happening with primary care here in New York. Right now we have about 2.3 million people who do not have adequate access to primary care. And unfortunately, with the Affordable Care Act, you'd think that that would get better, and eventually it can with the right policies. But we should see actually an exacerbation of this problem rather than a

mitigation. That's because more people will have insurance cards, more people will have Medicaid, they will seek access to care, putting greater strain on an already strained primary care system.

The New York State policy has looked to really address this, and I think the Governor's budget certainly makes some significant steps towards this. We're going to talk a little bit about some of those things and where we think they can go.

Number one, access to capital. There's a $1.2 billion fund, seven-year fund in the Governor's budget. We think this is a good idea. But we'd like to see specific money dedicated to diagnostic and treatment centers and other community-based providers to make sure that they have the access to capital they need. We saw in the HEAL program, which is just ending this year, that there was a lot of good -- some money went towards community-based providers, a lot of that went towards restructuring the system, and we're afraid that a lot of it

went towards institutional care and really did not get to have the impact that we thought it should have had.

Also with this capital money, right now it looks like it's straight grant dollars. You apply for the money, you get the money, you do the project. That's one way to do it.

We think a better way is to require some kind of leverage, make sure that providers have skin in the game. Have them have their own capital, raise capital, get capital foundations. That's a good way to extend, that can extend the money that New York has so it can have greater impact over more of the state. And it's a way to also have more rigorous projects because it's been through various reviews of various stakeholders. And we think this is a better way to go with this.

Now, there's been a lot of controversy around the idea of private equity, and we don't really take a position on the private equity in this pilot project.

But we just want to clarify that private investment has been a factor in New York's health system for a long time. This is what we do. We are a nonprofit that brings private sector capital into the sector. Now, this is debt, not equity. It's loans instead of equity. But it is investment all the same. And we look for the Legislature to explore solutions that will bring more community-based investors into this sector to really improve the health of communities.

I'm going to touch on the retail clinics. These are the limited service clinics and the urgent care centers. We are in general in support of what is in the Governor's budget. We've been working on this for over a year with the agency and the Public Health and Health Planning Council.

You know, there's a lot of feelings on both sides of this. But right now, these things are going to happen anyway. And we think that New York needs to get its regulatory hands around this to make sure that these are part of an integrated

healthcare system, not separate from it. And we think that both the intention of the Health Department and the legislation itself sets that path up to really connect in with primary care providers in a meaningful way. And we look forward to that happening.

I'm going to go over -- I'm going to skip a couple of things, but they are there. The Department of Health operations. You know, the department is extremely -- the mission of the department is very strong, and we support it. And they have a lot of very talented folks. But they have a lot going on. And with the waiver coming up and a lot of the other initiatives that are coming up, we would support more funding to help build their depth so they can execute on these really important programs for New York State's health system.

We support the Regional Health Improvement Collaboratives that were in the budget. We think $7 million is really just a start and we need a lot more investment. The State Health Information Network and the

All Payer Claims Database, these are two really important pieces of technology that we think are critical to getting our hands around the cost and quality issues in New York's healthcare system.

And then finally, the Legislature we were very grateful funded the PCDC $400,000 last year to help us in our mission, particularly in helping to really make sure that we have a good sustainable healthcare system, primary care system in New York. We'd like to see restoration of that fund.

And I look forward to your questions.

SENATOR KRUEGER: Senators? Assembly? Thank you very much.

MR. LOWENSTEIN: Thank you very much.

SENATOR KRUEGER: So next up is James Lytle, New York State Coalition of Long Term Care and PACE Plans.

And then to get ready next after James is Kathy McMahon, Hospice and Palliative Care Association of New York State, followed by Kathy Febraio, New York State Association of Speech-Language-

Hearing.

And you're on, James.

MR. LYTLE: Thank you very much.

Good afternoon. My name is Jim Lytle. I represent the Coalition of Managed Long Term Care and PACE Plans. There are 22 not-for-profit plans spread across New York State that are part of our coalition. They've enrolled about 90 percent of the individuals in managed long-term care. It's about a $5 billion program.

Senator Hannon and Assemblyman Gottfried will remember when this program was put in place, it was a fairly modest undertaking. Even as recently as few years ago, there was a total of about 10,000 people enrolled in managed long-term care. That number is now approximately 120,000.

There are just a few points I want to make, particularly given the hour of the day. The plans, as you know, are responsible for coordinating and managing community-based long-term-care services and

nursing home services that might be necessary for persons who, because of age or disability, require sustained long-term-care services.

There's nothing in the budget that's particularly -- any new policy direction that's particularly problematic. We've worked very closely with the department in the implementation of this program and consider ourselves still very much partners with the state in trying to improve long-term-care services. There are just three things that I think I would bring to your attention.

To operate this program, which are based on premiums like any other sort of insurance payment, it's important that those premiums be set on a timely basis. Dan Lowenstein and others perhaps during the course of the day have referenced the fact that the Department of Health staff, as talented as it is, is perhaps overstretched from time to time. They do an excellent job in dealing with a number of issues relating

to this program, but we still do not have our premiums from April of 2013, the adjustments that were supposed to be made now almost a year ago.

It's very difficult, if you're operating a program and responsible for the care of persons who are eligible for that program, to be able to operate it successfully when you don't have premiums on a timely basis. And the theory of the program is they're supposed to be set prospectively, and so it's been -- that has been a challenge.

The second and probably bigger issue is the adequacy of those premiums. As I say, there's a lot of money that has been shifted from other long-term-care services and now being spent on managed long-term care; as I say, roughly $5 billion. And as a result of that shift, there have been substantial savings achieved by the state in providing care on a more coordinated basis and with quality concerns being addressed.

There are a number of stresses on

whether those premiums are going to be adequate going forward. You've heard a number of individuals speak earlier today about the wage parity mandate. No group of individuals I can think of are more entitled to a living wage than folks who provide home care services. And we do not object to the obligation to make sure that they're paid an adequate amount.

Our problem is to make sure that the managed long-term-care plan premiums reflect an adequate amount of money to be able to pay for the very significant increase that needs to be paid to home health aides beginning just about a month from now.

To the department and the administration's credit, originally around $300 million was being recommended to address this issue. It's my understanding that even the department and its actuaries, who are usually never persuaded by things that we tell them, have been persuaded that they need to increase it to $350 million to come up with premiums that are adequate.

Not all that money goes to the plans; some of it goes directly to home care providers. But we're still, as other witnesses have testified, we're still confident that that number is significantly lower than it needs to be.

At the same time, another issue that I know Senator Hannon raised earlier today and that others have spoken to, just to compound this problem is the department has decided that after a decade of very clear direction to our plans that they can contract with either Certified Home Health Agencies or Licensed Home Care Services Agencies to provide certain services, it now appears that they may be required to contract with the more expensive Certified Home Health Agencies for services that have traditionally been provided by the licensed agencies.

That's going to be an added expense for little, in our judgment, of added quality. It will require higher levels of supervision, even though we don't think

that's necessarily warranted across the board. And the expense of that is also not being addressed in the current premiums that are received.

And then the final point I'd make is the last one in our written testimony. There was quite a bit of debate about the need to do something with respect to access to out-of-network care. It's a very important issue that we think applies primarily to the mainstream programs, the commercial health maintenance organizations and maybe elsewhere, but we don't think that imposing a new mandate of out-of-network coverage for managed long-term care was probably either intended by the Governor or by other proposals on this subject. But inadvertently, as drafted, it would apply to managed long-term care -- we think inadvertently. And whatever the merits of the proposal may be in general, we don't think it needs to apply to managed long-term care.

With that, I'd be happy to answer any

questions but I appreciate your consideration of this testimony and everything else you've heard today.

CHAIRMAN DeFRANCISCO: Senator Hassell-Thompson.

SENATOR HASSELL-THOMPSON: I just have one quick question. You stated that -- I believe I heard you say that the cost would be more. What do you attribute the higher cost to? Do they pay better salaries?

MR. LYTLE: What is taking place on March 1, 2014, is a requirement that says that all home health aides within New York City, initially, need to be paid what had been paid as a sort of the lowest payment under a collective bargaining agreement that was entered into a number of years ago.

There has been -- the Department of Labor and the Department of Health have worked out to figure out what that number is. And if my memory is correct, it's about $1.94 per hour more than had been paid for at least a significant number of home health

aides.

Again, we don't quarrel either with the calculation -- we have some questions about how they're going to implement this mandate. But it's a fairly significant increase. And again, perhaps well-deserved, probably well-deserved. But the problem obviously is we're supported entirely by these Medicaid premiums, and without adequate resources the managed long-term-care plans can't meet their part of the obligation.

We think $350 million is a significant down payment on the total cost. We think the total cost may be in the range of $400 million to $500 million.

We've continued to have conversations with the department about this. One of our frustrations is the Legislature has very little to do with our rates -- sometimes that may be a good thing. But the discussion is primarily between us and the department around this issue, and we're hoping to continue to make some additional

progress. But that's the nature of the cost.

SENATOR HASSELL-THOMPSON: Thank you. Thank you, Mr. Chairman.

MR. LYTLE: Thank you.

CHAIRMAN FARRELL: Thank you.

CHAIRMAN DeFRANCISCO: Thank you.

Kathy McMahon, president and CEO of Hospice and Palliative Care Association of New York State. On deck is Kathy Febraio.

MS. McMAHON: Good afternoon. Thank you very, much very much for the opportunity to speak this afternoon. I'll try to be brief, to the point, and talk fast. I appreciate very much the support you've shown for hospice and palliative care over the years.

To put my testimony in a little bit of perspective, I want to paint a very brief picture of what hospices are working in today, the environment they're facing. Our hospices, our members have huge challenges right now. Hospice Medicare reimbursement has been significantly cut through phaseout

of the budget neutrality adjustment factor, productivity cuts, and also sequestration. On top of that, a significant number of unfunded mandates have been placed on hospices. And I won't go into all of those; they're in your testimony.

I also wanted to mention length of stay in hospice in New York State is abysmally low. Our median length of stay is about 16 days right now. But I'm hearing from the majority of our hospices that the majority of their patients are on for two weeks or less, and within that group the majority are a week or less. I mean, it's not unusual for two to five days, which is not really hospice care.

The other thing that's disturbing in New York State, our utilization rate is only a little over 27 percent. Nationally, it's 44 percent. So we have a lot of work to do here in New York State.

I do want to thank the Legislature for recognizing hospice and palliative care as part of Medicaid redesign as well as the

Affordable Care Act implementation. I want to sincerely especially thank the Legislature for including in last year's budget the provision allowing individuals enrolled in managed long-term care to access their hospice benefit without disenrolling from MLTCP. That was wonderful, and we appreciate it very, very much.

I did want to let you know that our association is very, very committed to working collaboratively with managed-care organizations, and we've done a lot of work to position our members to work very collaboratively and facilitate relationships between the hospices and the MCOs. We spend a lot of resources, we develop a lot of tools. We're working on a return on investment template for our members, and we're working with the Health Care Plans Association and Jim Lytle's organization, hoping to do a palliative care education collaborative in the coming months on that.

So we'll continue to work on all those different projects. We also have been

and will continue to work very closely with the New York State Department of Health to facilitate the smooth transition of hospice being provided concurrently with MLTPC, and also on the carve-in of hospice into Medicaid mainstream managed care, which just took place this last October.

And one of the issues we're working with them on is the timely payment issue that was brought up by a couple of other folks who were testifying today. It's a big issue for hospice as well.

So I ask you that you please continue to support implementation of the Medicaid Redesign Team's recommendation regarding hospice and palliative care; that would be MRT 209 to expand hospice and MRT 109 to facilitate access to palliative care.

And that leads me into my next ask, and that's that you reauthorize the funding for the Palliative Care Education and Training Act, which was appropriated by you back in 2007, a long time ago. The Palliative Care Education and Training

grants that were part of that bill are a wise capacity-building, cost-effective investment in the future of New York's healthcare system. They also support the intent of MRT 109 that I just mentioned, and also the Palliative Care Access Act and the Palliative Care Information Act.

And also I ask that you ensure that hospice and palliative care play a strong role in the Medical Health Homes and the ACOs, which were also part of MRT 209.

I did want to mention implementation of FIDA, Fully Integrated Dual Advantage system. That's going to be taking place January 1 of 2015. And right now they're testing the different structures and processes for all of that.

I'm sure that you'll agree that a seamless access to the Medicare hospice benefit is important, and we ask that the Legislature make this a priority.

I also urge you to pay special attention to hospice in the nursing home and assure that there are no disincentives for

nursing home residents accessing their Medicare hospice benefit. I'm always very concerned about those unintended consequences; I think we're all very sensitive to that.

One other thing that's really come to our attention recently. FIDA has the new interdisciplinary team, IDTs. Also they're being developed right now. As they are implemented, we urge the New York State Department of Health and also CMS to assess and determine how the FIDA IDTs are going to interface and work with the hospice interdisciplinary team. The hospice IDT is made up of physicians, nurses, social workers, therapists, counselors, pastoral care and bereavement staff. And we just want to make sure that they're all working together.

I do need to talk about wage parity. I know a lot of the folks who testified today have talked about that. We certainly support fair wage, but we're very greatly concerned about some unintended consequences

and a negative impact on home health aide parity requirements and what that will have on hospices in the eight metro New York counties.

Hospices are paid on a per-diem basis. It's approximately $189 in the metro New York area. The per-diem rate must cover physician, nursing, social work, home health aide, therapies, medication, and durable medical equipment.

Despite the fact that the majority of hospice patients are Medicare patients, wage parity requirements will place hospices in really an untenable position. We're very concerned that LHCSAs may decline to provide aides for Medicare hospice patients, since they could be paid less, or that hospices will be forced to pay the higher $20.60 rate, which will mean that like a four-hour aide service, which is not unusual, will cost 43 percent of the per-diem rate, leaving a little over $100 to cover physician's services, nursing, social work, therapies, medication and also durable

medical equipment.

So hospices really need a managed-care rate sufficient to pay for parity in the downstate counties, which as I mentioned is the $20.06 an hour. So we recommend that parity be repealed.

However, if that remains in place, we have a couple of other options we think would be helpful. One would be that DOH should require this rate for a minimum of one year and should monitor the rates paid by adding a schedule to the Medicaid managed-care cost report that collects the rate paid to each LHCSA, or, two, require that DOH specifically include hospice patients' needs in the high hour/high need pool to be accessed by MLTC plans.

I did want to talk about recruitment and retention also. The much-needed HCRA support for recruitment and retention would be repealed under this proposed budget. Hospices are already struggling to maintain a well-trained staff that they need to deliver high-quality care to your

constituents.

Although the budget memorandum indicates that existing RTR funds would be maintained within provider base rates and MLTC premiums, it is not explicit in the bill. So we're very concerned about that. We urge the Legislature to maintain HCRA funding for RTR for hospice. Without this funding, employer-based training programs will not have sufficient funding to continue operation.

We're concerned that these changes will actually lead to less aide training at a time when more training is needed to assure availability of a skilled workforce.

I did want to support the HCA's testimony regarding emergency preparedness. Our members faced a lot of challenges during Hurricane Sandy and also Hurricane Irene because we did not have the essential personnel designation, and we would ask that you include that provision.

As far as improved information technology, we're very pleased that there's

funding for that included in the bill. However, we ask that you recognize the need to invest in making EMR software compatible with electronic prescribing software. Without the ability to interface, healthcare providers will be forced to work with ineffective, cumbersome systems that will require manual updating, which is an inefficient use of limited staff resources.

We really appreciate all the work that's being done to streamline Certificate of Need. Our association has done a lot of work on that. I won't go into detail; it's in our testimony. But I do want to thank you for passing and signing into law last year a bill that addressed several hospice residence issues. There are a couple still remaining. I won't go into the detail. But we would ask that you and the Public Health and Health Planning Council address several outstanding hospice residence issues.

Before I close, I really just wanted to touch on the Affordable Care Act. We are very supportive of the establishment of a

Basic Health Program and ask that you include hospice and palliative care. And also, when the state reevaluates the essential benefits package, we ask that you strongly consider integrating palliative care into chronic illness management and eliminating the 210-day limitation that was placed on the hospice benefit.

I won't go into a lot more detail --

CHAIRMAN DeFRANCISCO: I know you won't, because your time is up.

MS. McMAHON: It is, okay. Thank you very much.

CHAIRMAN FARRELL: Thank you.

CHAIRMAN DeFRANCISCO: Thank you very much.

The next speaker is Kathy Febraio, executive director, New York State Speech-Language-Hearing Association.

MS. FEBRAIO: Good evening. We'd like to thank the distinguished members of this panel for the opportunity to testify today on the 2014-2015 State Executive Budget proposal. My name is Kathy Febraio.

I am the executive director of the New York State Speech-Language-Hearing Association. We represent over 18,000 speech-language pathologists and audiologists statewide, many of whom work in the Early Intervention Program.

We would also like to thank you for the introduction of bills S6002 and A8316 that address the issues we're facing in early intervention.

I will now turn to over to my colleague, Sue Swiat, who will describe to you some of the day-to-day operations of working in early intervention today.

MS. SWIAT: Good afternoon. My name is Susan Swiat. I'm a physical therapist. I'm here today representing the New York Physical Therapy Association.

I've been a physical therapist for 35 years, 33 of which I've spent providing services in Early Childhood and Early Intervention programs. I'm also the partner in an all-women agency that employs 80-plus early intervention professionals in all

disciplines.

With all due respect, the testimony that Commissioner Shah gave this morning on the status of the current EI reimbursement system differs wildly from my daily reality. Because I spend my time in the trenches, I have been asked to speak of the administrative burden and some of the pain points, as PCG, the State Fiscal Agent, likes to call them.

First I'd like to dispel the myth that only independents or small agencies are struggling with this new change. As an agency, we didn't have the infrastructure in place to support this new billing system, as we didn't need to bill insurance previously by ourselves.

As a result of the new responsibilities thrust upon me, I no longer provide physical therapy services for young children and their families, which is my passion and which is why I originally entered Early Intervention. I have become a full-time billing administrator to keep my

agency afloat so that I can pay my 80 providers.

The percentages and the numbers presented this morning I feel are misleading, as Early Intervention Billing, the website of the State Fiscal Agent, only takes into account claims that have been cleared for adjudication. As we were attempting to reconcile what is reported to us as either submitted and/or paid in EI billing, our numbers just didn't add up and we couldn't figure out what was going on.

And after a lot of research on our part, we discovered that there is an elusive F file that shows up in the New York Early Intervention System, the NYEIS system, where some unclean claims go to languish. And there could be multiple reasons why they're there, but these claims have never even made it to EI fiscal agent to be billed to begin the adjudication process.

Once in EI billing and once they go to EI billing, there are many commercial insurance claims that languish there as well

because of problems with incorrect information, things like that.

Now, we just discovered this by accident in NYEIS. There's no notification that comes to us from NYEIS. And for us as an agency, because we had not known it existed, it turned out to be between $50,000 and $75,000 that was sitting there that hadn't even made it to EI Billing yet. So these claims, although they've been billed to EI Billing by us, they have not been included in those EI Billing totals, and even though I have already reimbursed my staff for the provision of those services.

So when all billing is considered, this brings my EI Billing percentage total down, from the 88 percent that's represented to me today on the EI Billing website, to only 69 percent.

Regardless of that percentage, this money has been reimbursed through my sweat equity, and I have not received any additional compensation for doing this work. For my agency alone, it has meant over a

hundred-plus hours per week that we have had to dedicate to these new tasks.

The new developments that the commissioner referred to as happening just within the last month include the Department of Health working with the State Fiscal Agent and insurance plans to get things running more smoothly. However, I have received direct knowledge from PCG representatives that I've talked to, and they themselves indicated to me that unfortunately, with several of the large insurance companies that I deal with in my municipality, and they're primary providers for me, they have not had any success in establishing helpful communications. So many claims from me remain unresolved with these insurance companies.

My experience with the six call center PCG employees in Nashville who Assemblyman Cahill referred to before, I speak to them on a daily basis, sometimes several times a day. And it's generally their advice that often comes back to me for

additional work for me to do to resolve the claim, including contacting families and service coordinators to verify information that was entered incorrectly in the system.

We have a huge problem with stale claims with children that have since aged out of the program. And we're just getting to try to do research on these claims, and no one to go back to for additional information to verify that the correct insurance or Medicaid information was put into the system.

I have had some PCG staffers tell me that I need to hire more staff to deal with deal with my 1500 outstanding insurance claims that I have to deal with.

I need to tell you that claim research is laborious and tedious and we have to go line by line and child by child to discover what the issues are, and then, only then, can we call PCG for some assistance, which often is not helpful.

I still have outstanding claims from March 2013, which to me are stale, in

commercial insurance and in Medicaid. And I have no hope of straightening these claims out due to faulty information that was initially entered into the system because we didn't have any or little or insufficient training at the beginning as to how to enter this information into the system.

I'd like to address the statement that there have not been negative impacts on program in terms of providers leaving. In my municipality alone, we have had 35 independent providers leave and one agency close. And I'd like to bring to your attention the fact that, as in my agency, my providers are employees, so they don't hold their own individual state agreements to be Early Intervention providers, they go under the umbrella of my agency's state approval.

So if an agency closes, you're not going to know that those numbers of providers have left because they didn't have original contracts with the state.

Secondary to this provider shortage we're seeing extended wait times to put

services in, which affects our ability to meet service implementation guidelines of getting services in within 30 days of an IFSP.

I deal with frustration on a daily basis, with conflicting guidelines between PCG and the BEI that leaves us stuck in the middle. Just one example is multiplan agreements that we started receiving initially. These were agreements from a central clearinghouse that many insurance companies contract with for a negotiated rate with us. And when we started receiving these in the beginning, after April, we didn't know what to do with them because it would be on $74 claim, they were offering us $48 and wanted us to sign that we would accept that amount of money.

When we questioned the BEI, they indicated to us that the rest of the money would be made up by escrow. We were uncomfortable with that, and eventually the BEI did issued guidance not to sign those plans, that we didn't need to, that that

issue was ironed out. But on the last EI Billing, the PCG webinar which was just done in November, beginning of December, we were indicated that we were indeed supposed to be signing those multiplan agreements.

So that's just one example of, on a daily basis, we ask PCG, they say ask BEI. When we ask the BEI, they say it's up to PCG.

MS. FEBRAIO: So due to these onerous working environments, we've been asking our members what they're doing about working in the Early Intervention Program. And we surveyed, along with the Physical Therapy Association and the Occupational Therapy Association, our members, who are primarily individual providers. And they've indicated that 49 percent of them are looking for employment outside of Early Intervention.

Unfortunately, 25 percent of them have already found it and have left. Although they may not have told the Department of Health about this, because once you end your agreement with the state,

you lose access to the data that might clean up your claims.

And most recently a coalition of Westchester providers surveyed agencies in the downstate area as well as the Southern Tier, and they have learned that 72 percent of agencies have reported children waiting for services, primarily in speech, occupational therapy, and physical therapy. Thirty-five percent have had payroll delays in the last year, and almost 52 percent of agencies are planning to reduce or close their Early Intervention Program.

So in conclusion, we are asking that you take the provisions of the bills that are already submitted on the Early Intervention Program and put them into the state budget, where we feel we will be able to save the Early Intervention Program if those can be passed.

CHAIRMAN DeFRANCISCO: What bill are you talking about, now?

MS. FEBRAIO: S6002, A80 --

CHAIRMAN DeFRANCISCO: Okay, S6002, A

whatever it is. If that's included, you say that will help resolve this issue?

MS. FEBRAIO: Yes.

CHAIRMAN DeFRANCISCO: Does it change the procedure for payment reimbursement?

MS. SWIAT: Yes, it would allow for us to be paid within 30 days of submission of a claim, and the burden of chasing and reconciling the insurance and Medicaid claims would fall back to the State Fiscal Agent.

And then any additional information they would need from providers we will be happy to provide, because that's our professional responsibility. But the actual chasing of the claim is not.

CHAIRMAN DEFRANCISCO: And then one other question. You were here when I was talking to Commissioner Shah. If you had to guess, what's the time frame from the time you submit a bill to the time you get a bill paid? What would the average be?

MS. SWIAT: Well, I can only speak for my municipality and my experience. But

before, with our contract with the municipality, we were paid within 60 to 90 days. And that's what we could plan for. We knew how to do that. Because we pay our providers within two weeks of delivery of service, but we knew we had that window and we could plan for that accordingly.

I have to say with the new system, if a claim goes directly to escrow because the child has no commercial insurance or Medicaid, we get paid much faster, sometimes within two weeks. But I have to tell you that the other claims -- like I said, I have over $200,000 languishing in commercial insurance claims that date back to March. So some of those claims it's 10 months -- many of those claims it's 10 months.

CHAIRMAN DeFRANCISCO: Thank you.

Senator Tkaczyk.

SENATOR TKACZYK: Yes, thank you for being here and explaining this.

I frankly was shocked when Commissioner Shah said this morning that there were no negative impacts. And clearly

there have been. And to not even recognize how difficult it's been to provide services to very young, vulnerable children to me is really unconscionable. So I applaud you for pushing us on this issue.

I have a couple of questions. The budget -- and because I'm concerned about what you're telling me, that we may not have a clear sense of what is needed in the budget to cover all of the claims for work that's been done in a prior year, have you looked at the budget numbers and do they may make sense to what the providers are seeing or what we think they are owed?

MS. FEBRAIO: I think we share that same concern, that the older claims from, you know, the earlier fiscal year will languish because there won't be funding left. We don't know.

SENATOR TKACZYK: Well, I would urge my colleagues to have further discussions with the commissioner on this.

It would help us to understand, from your perspective, what are the fiscal

obligations for payment from the provider's perspective and see if it matches up with the commissioner's statements or their perspective on what's owed. Because I'm afraid if it's not included in the budget you will not get paid for work you did. It's been extremely frustrating to try to get this changed and make sense for the providers.

I also want to know if -- you mentioned putting the legislation fix that initially I did a bill in October, the chairs of the Health Committee have done a similar bill. Do you want that in the budget? Would it make more sense for the Legislature to pass that legislation now and then get it -- would that help fix the problem? And can we start working on fixing it before the budget is passed? I'm just -- I don't know.

CHAIRMAN DeFRANCISCO: I'll answer. It's whatever goes faster.

MS. SWIAT: Thank you.

MS. FEBRAIO: We'll leave that to

your discretion, whichever.

MS. SWIAT: Because, I mean, we're 10 months into this process and we're hanging on by the skin of our teeth, basically, at this point. And some people have not hung on, they've gone under, so ...

SENATOR TKACZYK: Yeah, I think we want to do it as quickly as possible. And thank you for helping us understand this issue.

MS. SWIAT: And I just wanted to address what you had said about the number of, you know, past claims that are still there. That information is available, like what's impending. That's on EI Billing, the State Fiscal Agent's website. So each agency has that information available to them, what's pending.

SENATOR TKACZYK: It's something we want to look at and understand better.

Thank you.

CHAIRMAN DeFRANCISCO: Thank you very much. Very important issue. Thank you.

MS. FEBRAIO: Thank you so much.

CHAIRMAN DeFRANCISCO: Okay, American Cancer Society, Michael Burgess, director of government relations.

On deck is Barbara Crosier, vice president of government relations, Cerebral Palsy Associations of New York, and then followed by the American Heart Association.

MR. BURGESS: Thank you. I'll give you an abbreviated version.

I want to give you a status report on cancer in New York State. An estimated 109,000 New Yorkers will be diagnosed with cancer this year; 34,000 will die from cancer. But these numbers are actually better. The number of deaths has declined by 20 percent in the last 23 years. And that's no accident, because what you've all done, working with us on the research, the cancer screenings, the health laws like the Clean Indoor Air Act, these have all contributed to that. So we thank you for your support of this effort.

Let me tell you four things we're doing before I ask you for help. We have

300,000 people signed up nationwide for our Cancer Prevention Study-3, which looks at lifestyle, behavioral, environmental and genetic factors and follows those people over a number of years.

We have 270,000 people -- that's like an army -- walking in the Making Strides Against Breast Cancer fundraising walks, and even more in the Relay for Life.

And you know, all that money we raise, we put -- I'm glad to announce to you that $47 million of that has come back in 89 grants to the State of New York to academic and research institutions.

We're marking the 50th anniversary of the Surgeon General's first report on smoking in 1964. And it's a three-part strategy that has again worked here: Raising cigarette taxes, banning smoking in restaurants, bars and public places, and the funding for tobacco cessation efforts like our Smokers Quit Line run by Roswell Park.

Smoking rates have declined from 42 percent in 1964 to 18 percent nationally,

16 percent here in New York. People are living longer. The longevity in the United States can be attributed in large part to the drop in lung cancer and also in heart disease. And men especially are living longer because of these factors. Again, thank you for your help in that success that we have had.

But we're not content. Our goal is really, with the other major public health organizations, to reduce the smoking rate to 12 percent by 2020 and to 10 percent in 10 years. You have to have these kind of goals, like moon shots, you know. But we still have disparities. We still have folks who are living in rural areas, low-income, lower-educated, racial and ethnic groups, 25 to 30 percent smoking in some groups in this state.

And we really need to focus our efforts and work on those issues of disparities in the years ahead. That's why the fight is not done. 8800 people in our state will die from lung cancer this year.

Unfortunately the Governor's budget fails to provide the commitment, the leadership and the partnership necessary to help us attain these goals that I just mentioned. Once again the Governor is proposing to cut part of this budget -- $2.1 million in tobacco enforcement is put into one of these pools that will have to be decided by the Legislature if you want to go along with that. We don't support that.

We want to get the funding back up. It was $85 million for tobacco control and cessation seven years ago, and now it's down to 39.3. Calls to the quit line in Roswell Park, down 40 percent. We went from fifth in the nation to 21st in the nation in the amount of funding that we spent in relation to what is recommended by the CDC. We used to be a leader.

There is an independent evaluation required of the Tobacco Control Program which said "Continued underfunding of the program threatens continued progress toward reducing tobacco use and risk, perpetuating

tobacco-related disparities among the state's most vulnerable. Further reductions in tobacco use are put at risk by budget reductions that curtail the program's ability to reach a significant portion of New Yorkers."

The report stated a 1 percent decline in smoking rates would reduce annual healthcare costs by $554 million. And they recommend $127 million be spent on this program, a lot more than we've ever had. We are asking the Legislature to bring it back up.

We get over $2 billion in tobacco revenue in this state, in the Master Settlement Agreement. Tie a percentage of that, the funding for these programs, to a percentage of the money that we bring in. We think that that's only right. Half of all the births in this state are paid for by Medicaid. If we drop the smoking rate of pregnant women on Medicaid, it would save quite a bit of money.

The second program, the Cancer

Screenings Program, the Governor proposes to cut that from -- it was $29 million a few years ago, 25.3 last year, he proposes a cut to 24.8. And yet a study by the Health Department said the program saves $46 million. Even by their own estimate, it's far more than the appropriation level. And we still need to do these screenings to get people to find their cancer early.

Let me just quickly touch on some other things. You heard about the off-label drug issue earlier. Who is going to be impacted on that? It is largely cancer patients, because they have very specific regimens of drugs that are mixed by their doctors, or interchanged.

We need to fix that, throw that out. It's ironic the Governor proposes this when he allows medical marijuana to ease pain and suffering. But this would also help people, and he's not -- he's putting this in the budget.

We support and work with the Hospice and Palliative Care group that just spoke

about the need to restore funding for training. We think that pain management, comfort care is a critical part now, and it's becoming a key element of our agenda to do more in palliative care.

Many more people got insurance through the Affordable Care Act and, despite our criticisms of the administration, we think that in general there were some good things done with that.

Prostate cancer checkoff. The Rochester paper and many of you commented on the fact that the money that people checked off on their tax returns has not been spent. That needs to be fixed. And the Comptroller made a report on all of these checkoff programs and laid out an overview of that.

Out-of-network surprise medical bills. It's important that these protections be enacted. Again, cancer patients are very much impacted.

After years of delay and gridlock, it's time to do something about this. It's the purpose of insurance to shield seriously

ill patients from risk rather than create a labyrinth of exceptions and gaps. No consumer in New York State who has health insurance which he or she thought would cover charges for serious illness should unknowingly be held responsible for thousands of dollars which could bankrupt them.

So let me just close by saying that on behalf of all the thousands of volunteers who donate their time, who volunteer at the Hope Clubs all over the state, who walk to raise money for their family and friends and in memory of those who have lost their battle, they're committed to fighting cancer, they place a high priority on it, and we're asking our state leaders to be partners and continue that with us to make more progress.

Thank you.

CHAIRMAN DeFRANCISCO: Thank you very much.

CHAIRMAN FARRELL: Thank you.

CHAIRMAN DeFRANCISCO: Barbara

Crosier, to be followed by Julianne Hart, American Heart Association, which is very appropriate.

(Discussion off the record.)

MS. CROSIER: Good afternoon. Thank you. I'm Barbara Crosier, I'm with the Cerebral Palsy Associations of New York State.

Cerebral Palsy Associations was founded almost 70 years ago by parents look for services for their young children with cerebral palsy. Since that time, the 24 affiliates throughout the state have been offering a wide array of services for children and adults with disabilities and their families. While originally focused on children with cerebral palsy and other physical disabilities, our services have expanded to include children and adults with all types of disabilities and a variety of supports and services throughout their life span.

Today CP affiliates offer a variety of programs and services to over 90,000

people and their families across the state, and we employ over 18,000 New Yorkers.

Our affiliates depend upon Medicaid funding for almost 80 percent of their operating revenue, and now find the rates for these critical OPWDD supports and services are set by the Department of Health. These supports and services were developed over many years as New York State made a commitment to support the vulnerable individuals and families that we serve.

This recent shift in fiscal authority raises many concerns about the knowledge and understanding within the Health Department of the services and the impact of their decisions on vulnerable New Yorkers with developmental disabilities.

The separation of fiscal and programmatic responsibilities is troubling. We believe that there are numerous policy shifts and initiatives already in place that will undo much of the progress New York has made to ensure inclusion and access for people with disabilities.

We seek the Legislature's support in working with us to prevent any further harm to individuals with disabilities and their families and the supports that New York has had such a proud history of providing. We have come too far as a state and must continue to honor the promises made in the State Constitution and by New York's governors.

There have been significant funding reductions taken in services for people with developmental disabilities funded through OPWDD. According to the transformation agenda that OPWDD submitted to the Federal Centers for Medicare Medicaid, the enacted budgets for 2011-12, 2012-13 and 2013-14 contained more than $593 million in savings from cuts to not-for-profit supports and services for people with developmental disabilities.

At the same time that the Health Department has segregated its treatment of funding for people with disabilities, it has allowed spending for all Medicaid programs

funded under the global spending cap for enrollment and services to expand by nearly 4 percent overall.

Further, our state budget projections for growth in the OPWDD system seems to be a prime area to take yet another hit, as as much as $330 million is recommended to be eliminated from OPWDD service investment spending over the next three years as part of the Governor's gap closing. This funding would have supported critical new services for individuals with developmental disabilities.

Essentially, this elimination of funding represents another 2 to 3 percent reduction in OPWDD resources each year. As a result, thousands of New Yorkers with developmental disabilities either are being or will be denied supports or are only receiving very limited supports that do not fully meet their needs.

We urge the Legislature to provide funding so that individuals with developmental disabilities and their family

members in the community do not continue to be denied access to these Medicaid-funded services. In addition, we strongly urge that the global Medicaid cap be expanded to include OPWDD services funded through Medicaid as the best way to address this issue.

Cerebral Palsy has long supported the idea of including individuals with developmental disabilities in care management programs, and in fact we have established many systems that are being adopted in a care coordination model. Our affiliates have been providing Medicaid supports and services largely certified by OPWDD and are now under the fiscal authority of DOH. As such, we are concerned that the Medicaid State Plan considerations of some of the issues we are seeing in OPWDD aren't fully appreciated or understood by DOH, and we seek the Legislature's assistance in working with us to ensure that the potential OPWDD State Plan and HCBS Waiver Agreement threats are acted upon swiftly.

Specifically, we have had people waiting for as much as eight months to get through the "front door," which is a new policy through the Office for People with Developmental Disabilities, with no action by OPWDD to ensure that the Medicaid services described in the Medicaid State Plan are provided and the state's obligations met in a timely fashion. The "front door" is a failed policy that will threaten the New York State Medicaid program's standing with CMS.

Cerebral Palsy Associations has been working with the Health Department for years on our Article 28 clinic issues, on Early Intervention, on traumatic brain injury, and on the Consumer-Directed Personal Assistance, and we repeatedly have had to work to differentiate high-needs Medicaid patients served in our clinics from the typical patients seen by other Medicaid providers.

There was good reason our patients were exempt from utilization thresholds of

the past. And as we progress to capitated payments, the future of those high-cost, outlier patients is of paramount importance to us. Not only are we concerned with how we will be managed by fiscal intermediaries unfamiliar with truly high-need people, but more importantly we are concerned that Health Department staff do not know enough about the people we serve to develop good public policy regarding their access to care.

We ask that with rate setting and other fiscal decisions now in DOH that a Disability Clinician Advisory Council be created with DOH that staff must consult and receive direction from in the development of any policy or fiscal action that would affect the role specialty services for people with disabilities play in the health care delivery system.

Another example of where we believe DOH does not understand the people we support and serve has been in the development of a new rate-setting

methodology for services for individuals with developmental disabilities. Cerebral Palsy Associations understands the need for transforming the current system to one that is sustainable and, as such, has a rational payment system for providers. We also support New York State's efforts to comply with directives from CMS on controls for setting rates and reimbursing service providers.

The development of the proposed rate-setting policy has demonstrated that our population's unique needs are not understood by DOH. To make it very simple, they basically are looking at regional rates that are determined according to average number of hours and average salaries across the region. And those salaries are sort of regardless of whether someone has worked for a provider for 30 days or 30 years. I mean, they're just looking at averages and there's no good system or tool to look at acuity and the needs of the individuals and why they might need more services.

DOH staff and others continue to tell us that a similar methodology was used for nursing homes and that it worked well. Aside from the strong disagreement with the nursing home industry that this statement provokes, one cannot compare a 120-bed nursing home with a four-or-six-bed home where Olmstead, CMS and federal regulations require that individuals be integrated into the community, go out every day to either a work or day program, and participate fully in society and their community.

Cuts to hours and reimbursement for staffing cannot be covered by having staff "float" among houses that are blocks and miles away. The lack of any true understanding of how people's services will be affected by the proposal needs to be understood before the Health Department proposes a model that could harm the most vulnerable individuals that these rates are designed to support.

There is a very positive note in the Governor's budget, and again, also in order

to support and adhere with the Olmstead. The Olmstead Cabinet has recommended the expansion of the Nurse Practice Act exemption to non-certified settings so that individuals can live in more integrated settings in the community and have the access to administration of their medications without having to have a nurse, so that they can live at home, in their home, and not have to have a nurse deliver their medications. We strongly support that.

The Governor has also proposed restoration of the 2 percent across-the-board MRT cut for Article 28 clinics which we strongly support and would ask that you enact.

Additionally, in the 2 percent MRT cuts there was a cut to our Article 16 clinics that serve people with developmental disabilities under OPWDD. But rather than doing an across-the-board cut, again, the Health Department felt that people should only receive an average number of therapies.

And if you receive more than the average number of therapies, the individual was either denied the therapy or, in most cases, the Article 16 clinic provided the therapy as was in the physician's prescription and was just not allowed to be reimbursed for those therapies above the average.

And again, the average was not based on any clinical diagnosis or need or acuity, it compared physically healthy individuals with those with very complex needs.

So overall --

CHAIRMAN DeFRANCISCO: Excuse me. Can you see that clock? Is it close enough?

MS. CROSIER: Oh, sorry. I'm actually finished.

We just ask you to help us to ensure that individuals with disabilities are not harmed and that the success of the past is not forsaken. We appreciate your consideration. Thank you.

CHAIRMAN DeFRANCISCO: Thank you very much. Appreciate it.

Senator Tkaczyk is all refreshed,

she's back to start another round. Go ahead.

SENATOR TKACZYK: Just really quick, Barbara. There's a lot in here where you basically say DOH doesn't understand the work you're doing, the rates aren't where they should be because they don't -- there's a lot of nonunderstanding what you're doing coming across through your testimony.

How do you sit down with DOH and work through these issues? Do you have a formal arrangement where you're meeting with them and discussing these concerns?

MS. CROSIER: We have been meeting with them, and the Provider Council through OPWDD has been meeting with them. We've taken Jason Helgerson and John Ulberg on tours to try and show them the kind of individuals we're talking about.

But I think there's -- we have concerns that -- and it was in MRT No. 26 where, you know, it was average therapies or now average salaries and having average hours of needs. Which is one of reasons we

recommended that there be a council and we have medical directors that be consulted and help to explain the needs of these individuals with disabilities.

SENATOR TKACZYK: Did the council provide DOH with written recommendations? And if so, could you share that with me?

MS. CROSIER: We have not as yet, and it is not established, but we have in the past done written recommendations and clinical protocols that our medical directors have done for our clinics.

And we would be happy to work with the Health Department to work on those kinds of things, recommendations, and to explain the needs and why working on averages doesn't work with people particularly with more severe disabilities.

SENATOR TKACZYK: Yes, thank you. I'm just concerned that we make sure, as we're changing systems, we put in a system that makes sense to the providers and the people we're serving. Thank you.

MS. CROSIER: Thank you.

CHAIRMAN DeFRANCISCO: Senator Krueger.

SENATOR KRUEGER: Thank you, Barbara.

So you finished off by talking about they're using an average amount of services but if people are more severely in need of services, therefore they need more, you can't bill for that.

Is the other side true, that people who are less than the average need for services you can bill for the average, so it works out?

MS. CROSIER: If they're in -- there are two different averages. One is in this new rate rationalization where they're -- the new system to provide. And yes, under that scenario that they're working on, if traditionally or historically you've needed less hours or paid your direct support staff a lower salary, you get an increase. Your dollars go up or your rate goes up.

Whereas if you have higher needs, even if it's way below your costs, the rates

still go down in order to meet that average. So it's not really -- there is no good tool for looking at the needs of individuals with developmental disabilities and the number of hours they need.

So as a result they're doing this sort of average, which you're absolutely right, people who don't need the additional dollars or the additional hours will get increases, whereas people who are serving higher-needs individuals are going to get them cut. So -- you know, to come to a more regional rate.

But it doesn't make sense to provide additional funding for people who don't need it and take it away from individuals who do need it.

SENATOR KRUEGER: But again, if you're a provider who's got a fairly mixed -- I don't know if you call it a patient or a client -- a client population, it can sort of work out in the wash. It really depends on whether you've got a disproportionately large number of

high-needs clients.

MS. CROSIER: Yes. Right. And the Cerebral Palsy affiliates, because of how we were founded, tend to serve individuals that are higher-need, more medically frail, need more intensive services. Which is why, as a whole, the CP affiliates across the state are tending to be the real losers on this.

There are others too. If you are a provider who serves individuals on the autism spectrum or if you're a provider who serves individuals with severe behavioral needs, you know, medically frail, all of those high -- and agencies tend to sort of have a niche and serve a certain kind of individual or be known for that, and those are the ones that are going to be real losers in this. And it's millions and millions of dollars.

SENATOR KRUEGER: Thank you.

MS. CROSIER: Thank you.

CHAIRMAN DeFRANCISCO: Thank you very much.

Julianne Hart, American Heart

Association, followed by Steve Sanders.

MS. HART: Hi. I'm Julianne Hart with the American Heart Association. Thank you for the opportunity to testify today.

You have a copy of my detailed written testimony, which points out that cardiovascular disease, including heart disease and stroke, are the number-one and the number-four killer of New Yorkers. That's for both men and women and all racial and ethnic groups, that heart disease is the number-one killer.

Two major risk factors for heart disease are obesity and smoking. So I'm going to going to limit my comments to those two areas today.

In New York State, approximately 8.5 million adults are considered overweight or obese, and one-third of kids are considered overweight or obese. So because of that, we think that obesity prevention really needs to be a top priority.

Unfortunately, we feel the Executive Budget is actually moving in the other

direction, where obesity prevention programs and heart healthy programs are actually lumped together. So we were disappointed and we would urge you to reject that approach.

We were supportive last year of the bill that the Legislature passed to create the Governor's Council on Physical Fitness, Sports and Nutrition. We were disappointed in the veto, which stated that this should be included within the budget framework, which it's not in the Executive Budget proposal. So we would urge that the Legislature consider that approach and consider restoring funds to the Obesity and Diabetes Prevention line.

In addition, I wanted to echo comments from the American Cancer Society. We too have grave concerns with funding for the Tobacco Control Program. New York State has actually made great progress in certain areas when it comes to tobacco control. We've got a really strong Clean Indoor Air Act; we were out in the forefront there. We

have a high cigarette tax. And we have a fairly good Tobacco Control Program. But because of funding reductions, our progress has actually stalled in this area.

So while our adult smoking rate is 16.2 percent, if you look, there are huge disparities that remain. For people reporting poor mental health status, the smoking rate is over 35 percent. For people whose incomes are below $25,000, their smoking rate is approximately 28 percent. So there's gaps in populations that we're not reaching.

In addition, many of you have seen the hard-hitting ads which encourage people to call the New York State Smokers Quit Line. If these ads are not airing regularly, ultimately you're going to see a decrease in the number of users. So we have seen a decrease in the number of users statewide. For example, in Onondaga County from 2009 to 2012 we actually saw a 49 percent reduction in the number of users to the quit line. So ultimately, if funding

is cut, we see a reduction in these services.

And then lastly, I wanted to point out -- it's on the top of page 5 of my testimony -- while we've seen an increase in the number of youth that are smoking cigarettes, we've actually seen the opposite when it comes to other tobacco products. We're actually seeing an increase in the use of other tobacco products.

So we would strongly encourage that there be some price parity, and that will hopefully provide a disincentive for youth to use these other tobacco products. And we think that this tobacco revenue should be used for tobacco control.

So my exact recommendations are listed on the last page. And if you have any questions, please let me know.

CHAIRMAN DeFRANCISCO: Thank you very much. I guess you're off. Thank you.

Steve Sanders, executive director, Agencies for Children's Therapy Services, who's going to testify about something other

than the last time he testified.

MR. SANDERS: I'll do my best.

CHAIRMAN DeFRANCISCO: Is that correct?

MR. SANDERS: That's correct.

CHAIRMAN DeFRANCISCO: Okay, good.

MR. SANDERS: Ladies and gentlemen, I know the hour is late. You have my testimony; I'm not going to read it. I would recommend that when you have a moment, please do.

I might draw your attention as I'm speaking for a couple of minutes to the last page, which contains a survey that the organization that I am the executive director of, ACTS, conducted over the last several weeks. ACTS is an association whose member agencies provide a majority of the Early Intervention services in the State of New York.

The Governor's recommendation for Early Intervention in this year's budget is very clear. He makes no recommendation, no proposal. In other words, what the Governor

is saying is that all is well, no changes need to be made. And you have heard today enough testimony from providers and others who have indicated to you that all is not well and significant changes are in fact needed.

Senator DeFrancisco, you asked probably I think the seminal questions of Dr. Shah, and you deserve an answer. Because you didn't get answers from Dr. Shah. So I want to try to give you some of the answers you didn't receive and maybe tie up a few of the loose ends that you've heard about today and do all that in just a few minutes.

Dr. Shah indicated that 91 percent of the claims have been paid, to which, Senator, you asked, Well, tell me how long it has taken to reach that 91 percent figure. The commissioner couldn't do so. And the reason why he couldn't do so is that he doesn't know. Why doesn't he know? Because the system is so flawed that it really is impossible to know how long it's

taking to provide reimbursement to agencies and individual providers.

Why is this? Because let's just go back for a moment and remember what the change that you voted for in 2012 was all about -- at least what you thought it was, and how it turned out.

What you thought you were voting for was a measure that would do two things. Number one, it would relieve counties of their responsibilities and their expenses to bill and process Early Intervention claims. That was the first goal. The second goal was to maximize commercial insurance, recognizing that for 20 years only about 2.5 percent of the total payments in the Early Intervention system comes from commercial insurance.

And the Governor thought that by making this change in the billing process, that would do two things. Number one, it would save a lot of money for counties because counties no longer would have to bill and process these claims. And number

two, in hiring a State Fiscal Agent, which you were told was going to happen, and the State Fiscal Agent was going to pick up the responsibilities that were performed by the counties, that somehow that would maximize commercial insurance payments, saving the state and counties ultimately more money.

So what has happened since then? Counties are in fact largely out of the billing and processing system. They are saving money. But who's doing the billing is the question. Who is picking up the responsibilities that the counties no longer wanted because it was too cumbersome and it was too expensive? You would think it was the State Fiscal Agent, because that's what you were told two years ago. We'll hire an intermediary, the billing will go to the State Fiscal Agent instead of the counties, and State Fiscal Agent will process the bills and also maximize commercial insurance receipts.

Well, the first part happened. Counties are not doing the billing. The

second part is not happening. What providers are complaining about, rightfully so, is that virtually all of the billing and processing responsibilities have fallen on them, uncompensated. The counties had been receiving $13 million in aggregate every year from the state in order to do this processing. They're not doing it anymore. The providers are.

How much money are the providers getting to assist them in this billing responsibility? Zero. So they have dozens and dozens and dozens of hours of more work to do just to be billers now, not being compensated and threatening their services.

Dr. Shah said, Senator, that 91 percent of the Early Intervention claims have been paid --

CHAIRMAN DeFRANCISCO: No, he didn't say that.

MR. SANDERS: Well, yes, he did. He said that as of now, of the bills that have been submitted by providers, 91 percent have been paid.

CHAIRMAN DeFRANCISCO: No. No, he said in comparison to before the system changed, they were 91 percent of what was paid at the time that the last system that was used.

MR. SANDERS: Then the Commissioner misspoke. Because the documents that have been put out by the fiscal agent and the department talks about what percentage of the payments that have been billed since the beginning of the year have been paid.

And the fact of the matter is, as was also explained, the 91 percent figure isn't even accurate. Because as the previous speaker said, that doesn't even calculate all of the claims. That only calculates what they want to calculate.

Most of the claims during this period of time, from April 1 to now, since the transition, have taken three, four, five, six months to pay. There are still bills that are pending from April, May and June that haven't been paid. Commercial insurance is paying less. Not more, not

even the same. They're paying so far this year 1 percent, when they were averaging the grand total of 2.5 percent.

So this isn't working. It's not working for the providers, it's not working for the parents, it's not working for the state. But the Governor and the department stubbornly cling to the notion if we just stay the course and keep repeating the same flawed process, somehow it's going to get better. It's not getting better.

The point here is that in order for a provider to be paid now, with the new system, what has to happen is that commercial insurance in almost all the cases has to first adjudicate the claim. Nothing happens until the insurance company says "This is our responsibility" or "No, this is Medicaid" or "No, this is an uninsured claim." Until that happens, no nobody gets paid.

And because of that process, the second question you asked, Senator, which was how long does it take from the time of

adjudication to when providers get paid, Brad Hutton spoke up, you remember, at the very end, and he said, "Well, Senator, we think about it's 60 days from when the claim is submitted to when it's adjudicated." And then you said, "Well, I know about adjudication. What about when providers are paid?" He couldn't answer that question.

The fact is that even after adjudication -- which oftentimes doesn't take 60 days, it takes six months, eight months, 10 months -- claims still haven't been paid. But even at the point of adjudication, it's going to take at least another week, two or three weeks before the providers are paid.

So the bottom line is simply this. It's a flawed system. If we stay the course, it's going to remain a flawed system because the predicates to this system were all wrong. You can't rely on commercial insurance, who are collectively very good at avoiding paying claims, and even adjudicating them, to control when payments

will be made to providers.

The bills that were referred to, Senator, is a bill that has been sponsored by Senator Hannon and Assemblyman Gottfried. They've been reported out of the respective Health Committees. You had it correct, sir: However this dilemma, however this tangle can be corrected, the sooner the better is the way to go. The one thing we can't do is simply allow the status quo to continue for another year or beyond that.

So I thank you very much. I appreciate your patience. I hope you make it for tip-off, sir.

CHAIRMAN DEFRANCISCO: Thank you. Senate 6002.

MR. SANDERS: Correct.

CHAIRMAN DeFRANCISCO: Senator Tkaczyk, who doesn't care about the game.

SENATOR TKACZYK: I'll be really quick. I care about the kids.

MR. SANDERS: And it's 8316 in the Assembly.

SENATOR TKACZYK: So, Steve, before

you go, what about the budget? If we're concerned that we don't have a good allocation of what claims are out there that need to be paid, does the budget reappropriation funding reflect that?

MR. SANDERS: Nobody knows the answer to that question. Because once the claims are adjudicated, then it is the counties that have to contribute their share into the escrow fund before the providers get paid.

So if the counties don't submit, don't transmit their share into escrow, you still have a payment disconnect. So you don't know whether the money is sufficient, and you don't know when providers will be paid. If ever.

SENATOR TKACZYK: Thank you.

MR. SANDERS: Thank you.

CHAIRMAN DeFRANCISCO: Thank you very much.

Lauri Cole, New York State Council for Community Behavioral Healthcare, followed by Tracey Brooks.

MS. COLE: Good evening. I'm Lauri

Cole. I'm the director of the New York State Council for Community Behavioral Healthcare.

We have about a hundred members across the state that provide mental health and substance abuse prevention treatment and recovery services to vulnerable New Yorkers. That would include services that are provided in hospitals as well as free-standing clinics and, finally, counties that continue to operate services.

I'm pleased to be here with you today, and I just wanted to say thank you. Last year I was here to request that you provide some safety and some protective language in the budget that would require the state to take a look at really basic measurements as our system of care moves into managed care, and that included access to care, network adequacy, and some other very protective basic measurements that the state needs to look at as we make this transition. So I wanted to say thank you to all of you.

Some of my comments today may feel very mental-healthy or substance-abusey, and that is primarily because, as we all know now, these issues are public health issues. And while they also are fed by Medicaid and other dollars, it is also the fact that more and more, the issues that face persons challenged with mental health and substance abuse issues requires holistic care that includes health as well as mental health care. So forgive me if I stray back and forth.

One of the things I wanted to talk to you about is the painkiller and heroin epidemic in New York State. I know that there was some discussion this morning about it, but I wanted to put a fine point on it, if I may. And that is it's important to recognize that while these two epidemics, heroin and painkiller misuse and abuse, are seen as separate, that in fact in almost all cases of reported heroin overdose and fatality, it was the painkiller abuse and initial misuse of those medications that led

to the step into the heroin addiction and in most cases, when they're reported, to fatalities.

So I wanted to make that connection because I think it underscores what is not a sort of chopped-up, too processed, too overwhelming to deal with set of issues around addiction. It is instead a ladder that people follow from one point to the other unless there is intervention.

And my whole point in talking with you about this today is to say to you that as far as I know, there is no primary or major proposal in the Governor's budget that it intends to continue the work that this body and members of the Legislature and the Governor's office began with regards to I-STOP and other pieces of legislation that had a piece of the problem. And I just don't understand why.

I know that you would agree with me that in your local communities, in your neighborhoods and your towns, it's not just about substance abuse, it's about economic

health, it's about crime, it's about so many other factors that are so important to the quality of life in the districts that you represent.

And so I would say to you that perhaps you could get with your leaders and just begin to discuss what's missing from Governor's budget with regards to this issue. It is an epidemic facing us right now. You can't pick up a paper in New York State on any given day, in any community of the state, and not read about a death attributable to either prescription drug overdose or heroin. It's happening now. It's a now problem.

In addition, I wanted to just let you know that the behavioral health sector is transforming itself into a managed-care behavioral health service delivery system. In New York City that will begin in January 2015, and the rest of the state will go in July 2015.

There are a series of provisions in the Executive Budget that would assist our

system in preparing for this inevitability of managed care in the behavioral healthcare system. There are reinvestment dollars that are associated with state hospital beds closing as well as a reinvestment of those dollars to support community-based programs and services.

And at the same time, there are provisions in the budget that take a look at what's happening to our general hospitals right now. Those crises that are occurring in hospitals across the state are not only occurring in the medical/surgical divisions of those hospitals, there are psychiatric inpatient beds and services in those hospitals that are closing.

Ten years ago when we had the Berger Commission do its work, not one single bed was touched by that commission in terms of reforming the hospital-based system. It is now that we are in trouble, and it is including the psychiatric system. It is not just the heart and lung and, you know, the medical piece that is lost when a hospital

closes its doors or downsizes significantly.

So I would like to just ask you to support those measures that are in the budget for the mental health, substance abuse and move to behavioral health managed care, some of which are health, some of which are mental health and substance abuse.

I also wanted to just talk briefly about the capital and infrastructure grant, the $1.2 billion. You know, traditionally behavioral health providers have not been able to access dollars for things like health information technology, dollars for infrastructure repairs, dollars for capital investment. As my colleague Dan Lowenstein from PCDC testified earlier, there is a dramatic need for these investment of funds. And traditionally our sector, our subsector has not had access to any of the this money.

And so what you have across the state right now are mental health and substance abuse providers who are more and more providing primary care services as well, but who were not able in large part to apply for

HEAL grants funding. It wasn't written for them. There were perhaps two or three grants out of 22 or however many there were that made eligible our sector.

And so you have this incredible gap right now that exists across the service system between, I will say it, the haves and the have-nots. And it's not just based in the behavioral healthcare sector versus the medical sector, it's also based in the size of the organization and the complexity of the services provided.

And I would just encourage you to really think about ways that when a piece of legislation comes before you or a definition is used in a piece of legislation -- like, for instance, safety net provider, that's a definition we talk a lot about -- that you think about inclusion in those definitions. Our members provide high levels of Medicaid services. They also serve dually eligible individuals and uninsured individuals. Those are the NIH, National Institute of Health standards for what constitutes a

safety net provider. But we're left out.

And so what that means is in terms of the capital grants money as well as the DSRIP money, there's a question about whether or not our members will be eligible to apply or just simply be vendors to other applicants who are higher up on the food chain.

And so I think that if we believe that mental health and substance abuse are public health issues that affect the whole person, and the whole person in our communities, we have to also start thinking of them in an integrated way in terms of the advantages that certain of the subsectors have in terms of accessing dollars and resources.

Finally, I wanted to just tell you about a group of services within our continuum of care that are in trouble. The kids' mental health and substance abuse programs are not moving to managed care until 2016. It's a delay against the rest of the state in terms of the other

populations that are moving in.

And in the meantime, there are children's outpatient clinics and children's outpatient specialty clinics who are, for a variety of reasons, in great financial stress and distress. We're not sure that the majority of them are going to make it to the point where managed care kicks in.

And so just as you did four years ago when you made the Medicaid managed-care rate on par with the Medicaid fee-for-service rate, we're asking you to do the same for Child Health Plus. Child Health Plus is a commercial program with a Medicaid subsidy in it, and we think it's fair and pragmatic to assume that, given that, it should be paid on par with fee-for-service rates.

And now you now have the option of supporting a proposal that would change the rate-setting authority from the Department of Financial Services to the Department of Health, so the discussion comes up again.

So we would just urge you to consider making Child Health Plus on par with other

Medicaid subsidized services across the state.

We support the Nurse Practitioner Modernization Act. We do so because of the significant deficits in our workforce and the way that they are squashing our ability to meet demand.

In addition, again with regards to the issue of safety net providers, I just cannot stress enough how important it is that when a piece of legislation or a regulation comes before you that you please include in your thinking the needs of behavioral healthcare providers and their eligibility for those opportunities.

Thank you. Zero-zero, like right there. It's amazing.

CHAIRMAN DeFRANCISCO: You're right on the money. I'll tell you, you must have done this before.

(Laughter.)

MS. COLE: I have.

CHAIRMAN DeFRANCISCO: Thank you.

SENATOR TKACZYK: Because your

testimony was so succinct, I have no questions.

MS. COLE: Oh, thank you. See that?

CHAIRMAN DeFRANCISCO: Is the Heart Association still here? Because I think I'm going to have an episode.

(Laughter.)

CHAIRMAN DeFRANCISCO: Tracey Brooks, Family Planning Advocates.

I think the next two are speaking together, Housing Works and AIDS Community Research. Is that correct?

You're on deck.

MS. BROOKS: Good afternoon -- evening, actually -- Senators and members of the Assembly. And although we're in overtime, it's not nearly as fun as the SU-Duke game this weekend.

CHAIRMAN DeFRANCISCO: That is correct.

MS. BROOKS: I just wanted to talk to you -- there's a number of provisions in the budget that FPA supports, and we've handed it to you in our written testimony. What I

really wanted to focus on is the cuts that were sustained in the Family Planning Grant and are currently proposed in the budget, and the reason why we need to look at restoring the Family Planning Grant back to the 2012-2013 budget levels, which is just really a small restoration but makes a significant impact on the cost savings to the State of New York.

Guttmacher has just come out with their most recent numbers that show in 2010, based on the investment New York State made in family planning services, we saved over $459 million in public funds in 2010 alone. So it's really a very small investment, you know, just over a million dollars that we're talking about, that saves $450 million at the end of the day in overall public funding.

The Family Planning Grant is not just about direct-care services, it's about funding the safety net providers who provide family planning services to the women of the State of New York. We've seen in

Massachusetts, with the implementation of their universal health insurance products, that the need for healthcare services through organizations that are funded by the Family Planning Grant or the Title X funding of the federal government have not gone down just because some people received health insurance. They still come to our health centers to receive healthcare.

And much of what the Title X funding and Family Planning Grant here in the State of New York support are not only the direct care services but the nonreimbursable services that these patients need. And what we're talking about is outreach to high-risk populations, education within our communities, and longer appointments that have more counseling education to our patients that are unreimbursable.

So you've heard us today say for years and years and years for ever dollar spent, $4 is saved. Guttmacher has actually really shown you that in a one-year time span what those real dollars mean.

So family planning providers need to stay strong and whole right now as we make this transition from folks who are uninsured to people who are insured. That's not going to change the population of people who generally come to our health centers and their needs, for a number of reasons. There are always going to be people who are going to be fluctuating between health insurance products. We know when somebody signs up onto a private health insurance product they could have up to 45 days that they will be without health insurance. The Family Planning Grant would help for somebody who's up to 250 percent of the federal poverty level.

With people who have health insurance, under the Family Planning Grant and the Title X funding of the federal government, if they have high deductibles or copays, a family planning provider is required to, and we certainly do, put on a sliding fee scale those out-of-pocket costs. There are still some services that are not

covered with no out-of-pocket costs through the ACA that we would still want to ensure that patients are eligible for coverage on.

There are going to be a number of people who can't afford to be on health insurance and may take a couple of years and take the penalty. They'll continue to access healthcare services through the grant. And there will be a number of people who will never be qualified who are using family planning health centers today.

So this great legacy of family planning providers, this network that the state has really built over a number of decades, is still going to be necessary and strong. And the number-one top reason for that is that family planning health services are primary care for women of childbearing age.

What we've also seen from the Guttmacher Institute is that six out of 10 women who are receiving healthcare services say that we are their usual healthcare provider. Which means they may

see another provider for other reasons, but the provider they're seeing most regularly is their family planning health provider. And then four out of 10 women, it's the only provider that they're seeing in a year.

So this is the primary care provider that women choose. New York State has beautifully put together both public policy, payer policy, and it is the way that women access healthcare, so it's the practice of women to access their family planning provider as their main source of primary care, especially during childbearing years. And we are the continuity of care for them.

So I'm asking for the mere fact that the cost savings that the state lost last year alone because of the -- or that we will lose, pardon me, in 2014 as we institutionalize the cuts that we received in the budget last year, what I can let you know is there are a number of patients who are not going to be seen.

In Western New York we lost the full funding for the mobile van unit. The mobile

van unit out there went to rural areas in Buffalo and Niagara County, but also to urban centers in Buffalo and Niagara, areas that this state and the Legislature and the Governor are working very hard to provide an uplift.

These are patients that aren't going to go to healthcare centers, brick and mortar healthcare centers. We work with community partners and show up at their health center to ensure that we have healthcare services provided.

It was a five-day-a-week van. It's completely zeroed out this year. Through philanthropic giving, the Planned Parenthood in that area is going to be able to provide the van one day a week. That's four day a week that we're not seeing patients.

Two of our programs in the jails are no longer going to exist. Those programs saw women three weeks before they were released from incarceration to talk to them and educate them about family planning, contraception and the prevention of STIs.

One week before they left incarceration, our health providers came into the jails and provided a method of contraception for each of these women. Those women aren't going to be seeing care before they reenter into society.

Those were great programs that reached people (A) where they were at and (B) patients who were not going to seek healthcare elsewhere.

It is a very small amount of money we're asking for a very, very large impact on the State of New York. And we just ask for the Legislature to consider restoration back to the 2012-2013 levels.

And the final request that we would make is the continued support of the Legislature, both the Assembly, who for the last two budgets have put in $750,000 earmarked to the Family Planning Grant, and to the Senate, who respectively put a $500,000 and $550,000 line item for women's health.

What we'd ask the Senate to consider

is to also earmark that directly to the Family Planning Grant. The 51 providers who receive the grant are not only the nine Planned Parenthoods in the State of New York but direct counties, hospital systems, and federally qualified health centers.

So it's a way to get access to the full range of women's healthcare in a more succinct manner. Many of our members were able to access some of that $550,000 worth of funding, but it would be much better if all of them could.

So those were our only additional requests on the Family Planning Grant, and certainly I'm open to any questions.

CHAIRMAN DeFRANCISCO: Senator Hassell-Thompson.

SENATOR HASSELL-THOMPSON: Thank you. Thank you, Mr. Chairman.

Tracy, just very quickly, you're saying jails versus prison was where services were being provided for women?

MS. BROOKS: I'm sorry, I used the terms interchangeably. I'd have to look, I

don't have it right in front of me which facilities, but I do know it was in the Rochester area and then down in the Westchester-Rockland-Putnam area that we had those grants specifically. But I can check for you.

SENATOR HASSELL-THOMPSON: Where in the budget?

MS. BROOKS: I don't have the name of the --

SENATOR HASSELL-THOMPSON: You don't have the categories within the budget where the money was?

MS. BROOKS: The money was in the Family Planning Grant. And when the Department of Health and the Bureau of Maternal and Child Health did yeoman's work to really try to mitigate what the impact of the cut was going to be on family planning providers, what they did is try to hold direct services whole. And there's only so much room, after what's been going in the last five years of fiscal unsurety and balancing budgets.

So being able to restore that money back to the grant would allow us to be able to restore it back to those programs.

SENATOR HASSELL-THOMPSON: How much money?

MS. BROOKS: $1.3 million. And that's last year's cut. As opposed to what you're seeing this year.

SENATOR HASSELL-THOMPSON: These questions don't imply that I'm going to be able to restore them, Tracey, it just means that I know where to look during the budget process.

MS. BROOKS: I appreciate it, Senator Hassell-Thompson. Thank you.

SENATOR HASSELL-THOMPSON: Particularly because as we heard -- we heard the commissioner this morning talk about the good news in terms of maternal and child reduction in HIV and AIDS. And as we look at women who are having their babies in prison and some other services I, I just have a feeling that those services will be impacted as well. So it's of major concern

to me.

Thank you. Thank you, Mr. Chairman.

CHAIRMAN DeFRANCISCO: Thank you very much.

The next two speakers will be speaking together, Terri Smith-Caronia and Dan Tietz. Thank you for partnering.

MR. TIETZ: Thanks so much, Mr. Chairman. Well, we're covering very similar ground here, and so it seemed to make sense.

So I'm Dan Tietz, I'm the executive director of ACRIA in New York City. I'm here with Terri Smith-Caronia from Housing Works.

We're here to talk about the end of AIDS. We were very gratified that the Governor and Commissioner Shah referenced it this morning and that it was followed by, I thought, well-put questions from Senators Hassell-Thompson and Hoylman, among others.

We think we're at a critical moment in the epidemic. We've got the tools, the resources, the knowledge, the means to end

the epidemic. And New York, as the Commissioner sort of hinted at, is particularly well-positioned in this regard.

New York does better than virtually all the states in terms of undetectable viral loads, for getting folks on their anti-HIV medications and keeping them on those meds such that you can't any longer detect virus in their blood. They're not cured, they still have HIV, but you can't detect it.

And that makes a huge difference in terms of prevention. It reduces the risk to others by up to 96 percent. And the very medications that are used to treat HIV can also be used to prevent HIV in those who are HIV-negative, and we want to keep them that way.

So we've got the tools and the infrastructure in place to do this and to do it right. But what I think we were disappointed by in terms of the Governor's budget is that it didn't include any of the items that we think are necessary to get

from here to there.

So we think the intention is right, we think the leadership is there, we have the support of the folks at the AIDS Institute and across the Department of Health and the Commissioner, as well as the folks on the second floor. But that's going to require some resources.

So if you look at my testimony, the bottom of page 2, top of page 3, we list a few of those items that we think that need to show up here.

Ten million dollars in new funding for the AIDS Institute to implement any plan that gets developed by a task force to be named by the Governor. I think what the Commissioner didn't say, although they've said to us privately, is that they're in favor of that task force, they're urging the Governor to do that.

In affordable housing protection, the 30 percent rent cap. We think that's vital so some of the structural barriers that exist out there to getting folks into care

and keeping them in care certainly relate to housing and housing supports, and that would make a huge difference.

In addition, Article 7 language to eliminate the use of condoms as evidence of prostitution by police and prosecutors. Obviously that's a very counterproductive message in terms of public health. If we're going to arrest people for the mere possession of condoms, that's a serious problem.

And then Article 7 language to legalize the possession of syringes. Again, we've seen the impact of syringe exchange. This would make a huge difference in terms of reducing the spread of HIV.

And in fact, to get to Senator Ruth Hassell-Thompson's earlier question today, there are a couple of things that have reduced mother-to-child transmission to just two cases last year. One of them is syringe exchange. One of the ways in which women get HIV is either injection drug use or that of their partners. So having clean syringes

makes a huge difference here.

The second, which we reference a bit as well, is testing. So HIV testing of all pregnant women as part of prenatal care goes a long ways towards preventing HIV. So even if they have HIV, we can give them medication to prevent the spread of that HIV to their newborn infants. So it makes a huge, huge difference. This has been proven around the world; it's very effective. So I think what we really need to see here is that kind of leadership.

Oh, I just want to mention this as well, before I pass this to Terry, that there's another big sort of shift here that needs to happen -- and I think it's in conversations going on now between the Medicaid director, Jason Helgerson, and Big Pharma -- which is to get New York a further reduction in the cost of antiretroviral drugs from the current discount that Medicaid gets.

So Medicaid gets about a 44 percent discount off list price now. They're asking

for a larger discount for those who would come into care as a result of any initiative to end AIDS in New York State. As we understand it, they're close to a deal on that with one of the key makers. That would make a huge difference, because we can reinvest those dollars then in the other bits and pieces that need to be invested in in order to get to the end of AIDS.

Thank you.

MS. SMITH-CARONIA: Awesome. Thanks for that, Dan, and thank you, Senators, for allowing us to speak.

If folks actually promise to read this, I won't have to read this. Everybody promises with their hands up? Very good.

CHAIRMAN DeFRANCISCO: I promise. I promise.

(Laughter.)

MS. SMITH-CARONIA: Okay. So I just basically wanted to touch on the four and add an additional point from what Dan mentioned in his testimony, and it's basically talking about what was omitted

from the budget.

While the budget this year for people living with AIDS and HIV didn't do real damage to the AIDS Institute, there were glaring omissions in what that budget did not have in it that would move us closer towards ending AIDS as an epidemic here in New York State.

And very briefly, and I'm going to skip a lot of paragraphs because you promised to read it, the long-awaited 30 percent rent cap. I know you all know what this is. Raise your hand. Very good.

CHAIRMAN DeFRANCISCO: You're out of order.

(Laughter.)

MS. SMITH-CARONIA: Very good. Well, I'm just helping you move this along.

(Laughter.)

MS. SMITH-CARONIA: The $10 million placeholder, that basically starts the task force, as Dan was talking about. And that would help to seed some of the programs and initiatives that would come out of the task

force to help end AIDS as an epidemic here in New York State.

And honestly, this is something New York State should really be thinking about, and the Governor and the Legislature should step out there and do it because we could truly be leaders in this country if we're doing this. Other states are actually waiting for the plan that New York produces so that they can replicate it. So we really need to get busy in doing that.

The anticipated changes to legislative language that would end the current police practice of confiscating condoms to use as evidence of prostitution, that was not in the budget.

Now, all of the things that we're mentioning had a chance of actually being in the budget, got into the budget initially, and was taken out, either due to negotiations that didn't happen in a timely way or due to pieces of the legislation that needed to be fixed. So we're not putting forward something that the second floor is

like unaware of. This is something that they know that they need to sort of negotiate with.

And just like the 30 percent rent cap, and you've asked other people this before, we don't care whether or not the Governor does this, whether or not the legislators do it. Just get it done. Just get it done. It's like it's cold out there, people need a place to stay, that's the bottom line. And this actually reduces healthcare costs for people that don't have to go into emergency rooms because they are being stably housed.

So that's one of them. And the last one that we have here is the doubling of the amount for the HIV Welfare-to-Work Program. And I know you're wondering why I'm bringing that up now. Because this is a shared program between the New York State Department of Health AIDS Institute and OTDA. This is a program that has been proven effective since 1999.

It's been systematically whittled

down, whittled down, whittled down, and now we're asking you to actually double the amount that's currently in the budget, which is $1.161 million, far less than what it was originally allocated. So doubling that amount doesn't even bring it back to the original amount of money.

But this is something that, too, goes towards ending the plan because to get people stably housed, to get them gainfully employed also helps them to be retained in medical care and to be adherent to their drug regimen.

So I believe that is it. Thank you very much for allowing us to testify.

CHAIRMAN DeFRANCISCO: Thank you.

Senator Hassell-Thompson.

SENATOR HASSELL-THOMPSON: Thank you, Mr. Chairman. I'm glad I left and had lunch. I'm back and ready.

(Laughter.)

SENATOR HASSELL-THOMPSON: Dan, you said that -- we looked at the two items that were missing, and that's the Article 7

language for condoms. And the other was -- I'm assuming that you're proposing a statewide initiative to legalize the possession of syringes.

There are some communities, I know the Urban League has been successful in some communities in getting a needle- exchange program, which has apparently been very successful. And in those areas we've seen a significant drop in new cases, which is an excellent argument for doing this broader.

What have been some of the obstacles to getting that moved?

MR. TIETZ: I think most of it has been around misunderstandings. I think that there are some folks who believe, and frankly quite mistakenly, given all the evidence to date, all the research that's been done, that somehow possession of syringes or syringe exchange programs increase drug use.

They do not. They only decrease disease. Moreover, they also are a gateway for folks not into drug use, but instead

into treatment. So to the degree that folks have to engage with somebody to get possession of clear syringes, then they're also engaging with a provider around their substance use and to reduce further harm to them, reduce their use, ultimately maybe get into treatment. It's those interactions.

So in every regard, it's a perfectly sensible public health measure to legalize syringes.

SENATOR HASSELL-THOMPSON: And I'm assuming that the church has put the kibosh on the condoms? Or the influence.

MR. TIETZ: Well, thankfully the church doesn't run New York State. And thankfully, I guess as well, there are a variety of opinions -- well, I'd like to imagine it doesn't run New York State.

And there are a variety of opinions, depending on which church you're going to, or mosque or other house of worship, with regards to condoms. So there are certainly some religions that may frown on condoms, but I don't think that should drive public

health policy.

SENATOR HASSELL-THOMPSON: I don't disagree. My last job before coming to work in the State Senate was to do drug adherence around HIV and AIDS. I had a Ryan White Project that I was responsible for. And one of the biggest obstacles in the beginning was getting churches to break the silence. And we did a lot of work with churches.

And it was very interesting, we went to an Epistolic church, which we had this whole plan for how we thought we would approach them, because they're very different from Baptists and from Methodists. And it was interesting that the women said: Just cut to the chase. Give out the condoms. And it just kind of blew us all away, because that was not what we had all expected.

But I just think that we just have to keep the message going that if we're really going to do anything to bring down the numbers of new cases and certainly cross-infection, that we've got to do

something better or more in terms of the language that we use in our Article 7.

So thank you. I appreciate your coming, both of you, and testifying today, because these continue to be major issues in my community and communities of color.

CHAIRMAN DeFRANCISCO: Senator Krueger.

SENATOR KRUEGER: Hi. Thank you so much. And I haven't seen you in a long time, Terri. Nice to see you up here. Both of us are getting a little older.

I was going to ask also the question about syringe use, because there's been so much discussion, particularly in upstate New York recently, about the growth in heroin use. Shouldn't we be worried that that new heroin epidemic that people are talking about is going to lead to an increase in HIV transmission unless we ensure that people have access to clean needles?

MS. SMITH-CARONIA: Absolutely. And that's why we're asking for the expansion

and continued funding for syringe exchange programs. And the decriminalization of syringes actually allows folks who can now go into various pharmacies and purchase clean syringes, and the cap on those purchases is currently at 10. At 10.

So we're saying there should be an unlimited -- like no cap on purchases of syringes. We're actually calling for the State Department of Health to allow pharmacies to advertise the fact that you can go in there and purchase syringes, where currently right now they can't.

So people need to know that these tools are available to them to keep themselves HIV-free.

SENATOR KRUEGER: Thank you.

And while I hate ever disagreeing with my colleague and friend Ruth Hassell-Thompson, for the record the current pope, Pope Francis, who's my personal favorite pope -- which is a little confusing, as a Jew -- my personal favorite pope actually thinks that condom use to

protect against transmission of disease is totally consistent with Catholic teaching.

So the church and we can all be on the same side here. So just for the record.

MS. SMITH-CARONIA: Thank you.

SENATOR KRUEGER: Thank you.

CHAIRMAN DeFRANCISCO: The pope and Krueger. That's great.

(Laughter.)

CHAIRMAN DeFRANCISCO: Thank you very much. Thanks for joining together.

And Medicaid Matters New York is here, Lara Kassel is going to testify. She only brought one copy of her testimony, but she's going to get copies for us to distribute. Correct?

MS. KASSEL: Yes, absolutely.

CHAIRMAN DeFRANCISCO: Okay, thank you.

MS. KASSEL: Thank you very much. I appreciate this opportunity, particularly at the late hour. Because I was a legislative staff person many years ago, I also want to thank the staff for being here.

Medicaid Matters is a statewide coalition of over 140 organizations representing the interests of people who are served by the Medicaid program. We were very pleased and proud to celebrate Medicaid Matters' 10th anniversary last year, and we look forward to many more years of advocacy on behalf of Medicaid consumers.

Before I get into some aspects of Medicaid redesign that I want to share with you as they relate to the budget this year, I want to touch very quickly on the implementation of the ACA in New York State and the creation of New York State of Health, the health insurance marketplace.

Medicaid Matters is involved in a workgroup that is now meeting monthly with the Health Department to look very closely at how Medicaid is being integrated into the implementation of the ACA in New York. And we're very proud to be able to do that work and to look at things like how people who are attempting to enroll in Medicaid, how they experience going to the website or the

call center to enroll in Medicaid through a new system. So that's some of the work that we're doing there.

As it relates to the state budget, the budget, as you know, proposes to create a Basic Health Program. We're very supportive of this, as it would use public funding to insure people who are just above Medicaid eligibility. This is the opportunity for these folks to be covered by a public program and for the state to be reimbursed for doing so.

As it relates to Medicaid redesign, Medicaid Matters was, despite its shortcomings, supportive of the Medicaid redesign package and, in addition, was supportive of the MRT waiver application that was submitted to CMS in August of 2012.

Since that time, as you may know, the application is drastically different. We are now parsing through what that actually means. There was a lot of discussion today about the DSRIP, the D-S-R-I-P, Delivery System Reform and Incentive Program. This

is about three-quarters of what the new waiver application is. And if successful, the state would use $7.5 billion for this DSRIP plan to dole out money to hospitals and other providers for programs and projects that would aid in reducing avoidable hospitalizations.

Medicaid Matters has written comments on the DSRIP plan and other aspects of the MRT waiver, which if you have not yet seen, I'm happy to furnish to you.

Just to highlight a couple of points, we're particularly concerned that funding be allocated for projects in as transparent a way as possible. That is actually something that is included in the DSRIP plan, and we're very appreciative of that.

We also want to make sure, as other folks have said today, that funding be appropriately allocated to community-based providers. Community-based providers of course we know are the ones that actually do reach people in a way that other larger, sometimes hospital-based providers may not.

Of course that's a generalization, but we want to make sure that community-based providers and safety-net providers are included in the allocation of funding through the DSRIP.

Moving on to other aspects of Medicaid redesign, the MRT process and the final enacted MRT package included an expansion of Medicaid managed care in a pretty drastic way. To put this even more bluntly, Medicaid in New York will no longer be provided on a fee-for-service basis, it will be a model that is entirely provided through Medicaid managed care.

And this of course has worked for many, many years for lots of people in the Medicaid program. But now Medicaid will be provided to people through managed care who were previously exempt or excluded from having to use managed-care plans for their care. And this is concerning in many ways. We've already seen how it's working for some populations, and we've been doing a lot of work, our members in particular have been

doing a lot of work to look at how that's working.

A couple of years ago Medicaid Matters put forth a proposal to create an ombuds program -- not to be confused with the existing Long Term Care Ombudsman that exists in New York State, but an ombuds program that would serve to provide individual and independent assistance services for people who are new to managed care. And that would be services on the ground provided by attorneys and people with expertise in disabilities to provide assistance to folks who need help navigating using Medicaid through a managed-care plan rather than on a fee-for-service basis.

There is a small amount of money in the budget, there was a small amount last year as well. There's another amount this year to make sure that that program gets up and running, and we hope that that will happen in the next several months. That program will go a long way to make sure that people have assistance as they navigate

Medicaid managed care.

There were a couple of provisions that were not included in the budget. They were part of budget negotiations, as we understand it, at the 11th hour during last year's budget negotiations, and they would serve to provide some important consumer protections in Medicaid managed care.

One of them is -- we call it exhaustion. We hope that the state will consider eliminating the requirement for folks to exhaust internal appeals before they can go outside for an external appeal. This is a particularly arduous process, particularly in managed long-term care. And as we know, the folks served by MLTC are folks who are particularly vulnerable.

The other we refer to as aid continuing. In managed long-term care, folks are very often reviewed for services and then their services, their hours are reduced. We want for aid to continue, that's why we call it aid continuing, while their rights are being pursued. So, for

instance, if they go for a fair hearing, that the same level of services be continued while that process is going.

We have a number of different areas related to Medicaid, but we want to make sure that as they relate to Medicaid managed care, as other folks have said today, that as other populations and other services are transitioned into Medicaid managed care, particularly two areas that were included in the Governor's budget: Support for foster care transition -- this is a population that's particularly vulnerable, and their services need to be preserved and access needs to be preserved as they transition to managed care.

And as other folks have said today, the behavioral health transition to managed care will also be particularly arduous, and we want to make sure that these are investigated and that particular care be taken as that happens.

I'll just mention some of the other things very quickly. We are very supportive

of regional health planning as long as it includes community representation and consumer representation. We hope that the Legislature will preserve spousal and parental refusal. We hope that you will preserve "prescriber prevails" provisions. And we will provide to you our written testimony and other materials as the process continues.

Thank you.

SENATOR KRUEGER: Thank you.

CHAIRMAN DeFRANCISCO: Thank you very much.

And the final speaker, who has the patience of a saint, Leslie Grubler, UNYEIP.

MS. GRUBLER: Senator, we again have the pleasure of presenting last. And I think we're getting used to this position, but we understand that you've saved the best for last.

CHAIRMAN DEFRANCISCO: That's correct. But next year, whoever is sitting in this chair, I recommend that you be moved up in the order.

MS. GRUBLER: That's okay.

I'm not going to bore you with the details. We're very pleased this evening that Early Intervention was prioritized today. And we hope that it continues in the future budget negotiations. I'm just going to mention a few things, hopefully that were not mentioned already.

First, thank you for the opportunity to testify today on Governor Cuomo's 2014-2015 Executive Budget and the Executive's exclusion of Early Intervention in the state's $2 billion surplus.

A few items. The Hannon-Gottfried bill, which you've heard a great deal about. However way the Legislature feels that they can enable this bill, whether it's within the budget or outside of the budget, please do so ASAP. I think both bills already have significant support in both houses.

Number two, the bureaucracy grows while providers close. And this is on page 2 of the testimony. And it indicates that over 40 Early Intervention agencies have

closed and uncountable providers have left the field. And, daily, providers' practices are on the verge of collapse. At the same time, the SFA, the State Fiscal Agent, demonstrates its efficiency in FaceTime and delegating their responsibility.

Number three, forgive but don't forget. And when I say forgive but don't forget, I'm speaking to all of the legislators. Because on page 3 is a printout of what was planned. And this actually came from the RFP for PCG. This is what was planned, this is what you had voted upon. And then if you turn to the next page, on page 4, this is actually what resulted. And every blue box you see on this page reflects the providers' responsibilities, which are significant.

On page 4 you've heard a great deal of data from the agencies, both small and large, today. And UNYEIP, which is composed of parents and independent contractors and small agencies, has also surveyed the parents. And you'll note on page 5 of the

testimony it indicates preliminary data: 24 percent of parents report that their child is not receiving services that appear on their child's IFSP. Fifty-four percent of parents have been waiting for services for one to three months, and 13 percent have been waiting four to six months for services.

Fifty-four percent of parents indicated that neither the county nor the service coordinator have contacted them to advise them of when their services could begin, and 84 percent have not been advised that there's even a waiting list in the county.

Parents have continued to receive provider checks from insurance companies. Some are being told to sign it over to the provider, others are being told to send it back to the insurance company, others are being told to send it back to the county, which just adds to the deep black hole.

And the stability of the provider workforce. The parents have indicated that

30 percent of their providers have changed since the inception of their child's IFSP. And if you know anything about Early Intervention, stability and consistency is important to our state's most vulnerable children.

On Section 5 I talk about miscellaneous concerns. Recent data as of the 1/27 steering committee meeting, PCG reported that January has the highest level of unadjudicated claims. Well, if you take a look at that little graph about New York State of Health, look at the percentage of new enrollees in New York State of Health alone. I feel like saying, Duh, this is the reason.

But has PCG or the Department of Health properly trained the service coordinators to ask parents, Have you changed your insurance company? Because if they have not, then the old insurance information is still in the system, and our providers will not get paid.

In the first week of December UNYEIP

sent an 11-page memorandum from a number -- it was a sampling, actually -- from a number of our providers of all of the issues. The next week in December we sent a copy to the BEI. This week we followed up with all of our providers to see if any action was taken on the 11-page document, and our providers have indicated that no action was taken.

I've also, in Part 6, indicated noncompliance with federal IDEA Part C regarding rates and the noninclusion of this administrative burden in New York State's consideration of rates. And I've also provided Early Intervention, a retrospective, but I don't think I have to review that with this team here.

And just as a summary, changes to this budget proposal integrating the Early Intervention Gottfried-Hannon legislation must be dictated by what is best for the state's most vulnerable children. Funding for Early Intervention must be dedicated and predictable and shielded from the annual changes embedded in a budget process at the

whim of an Executive. It's time to say no, it's time to stop the chipping away of a program that means everything to families, everything to the future of these children, and everything to our society.

Mayor de Blasio said in his testimony, "We are in the midst of an inequality crisis" in the care of children in our state. Yes, there's much talk about early education, but none about Early Intervention. In New York State, a commitment to the children must include a commitment to the children with special needs, the state's most vulnerable children, those of Early Intervention.

And I end this testimony with a piece of data that you've been asking for, what is the total dollars that are owed in unadjudicated claims. And in the January 27th meeting of PCG, they indicated that there's presently $37.5 million. It was Stephen Greene from PCG that indicated $37.5 million presently is in unadjudicated claims for Early Intervention.

CHAIRMAN DeFRANCISCO: Thank you very much. And you don't have an entire bureaucracy behind you to answer that question.

MS. GRUBLER: Yeah. Thank you.

CHAIRMAN DeFRANCISCO: Thank you very, very much. And we appreciate it. And hopefully whoever is here will be moving you up in the order next time.

MS. GRUBLER: That's okay. Thank you.

ASSEMBLYMAN OAKS: And we do thank you for the Early Intervention services that are provided and giving us today -- we've had a lot of discussion -- but an understanding of what we need to do both in getting payment made but also services delivered. So thank you.

MS. GRUBLER: And I'm available at all for any further discussion on this. Our website, *UNYEIP.org*, has all of the videos from the Assembly hearing as well as the Q&A that occurred in October of the DOH that provides a wealth of information.

CHAIRMAN DeFRANCISCO: Thank you again.

And thank you to our Iron Lady over there, that's the stenographer.

Thank you very much, and we're adjourned until 9:30 tomorrow morning to do it again.

(Whereupon, at 6:54 p.m., the budget hearing concluded.)