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SENATE FINANCE COMMITTEE

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-and-

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ASSEMBLY WAYS AND MEANS COMMITTEE

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Subject:

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2010-2011 Joint Budget Hearings

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Health/Medicaid

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Hearing Room B

13

Legislative Office Building

14

Albany, New York

15

16

February 9, 2010

17

10:01 a.m.

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B e f o r e:

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SENATOR CARL KRUGER

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Chair, Senate Finance

22

Committee

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ASSEMBLYMAN HERMAN D. FARRELL

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Chair, Assembly Ways and

25

Means Committee

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A P P E A R A N C E S:

For the Senate:

- Senator John DeFrancisco
- Senator Thomas K. Duane
- Senator Kemp Hannon
- Senator Craig Johnson
- Senator Liz Kreuger

For the Assembly:

- Assemblyman James Baccalles
- Assemblyman Philip Boyle
- Assemblyman Clifford Crouch
- Assemblyman Jeffrey Dinowitz
- Assemblyman Richard N. Gottfried
- Assemblyman James P. Hayes
- Assemblywoman Earlene Hooper
- Assemblyman Dave McDonough
- Assemblyman Marcus Molinaro
- Assemblyman Joseph Morelle
- Assemblyman Michael Spano

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4 SENATOR KRUGER: Pursuant to
5 the State Constitution and Legislative Law, the
6 fiscal committees of the State Legislature are
7 authorized to hold hearings on the Executive
8 Budget Proposal.

9 Today's hearing will focus on
10 the Governor's proposed budgets for the
11 Department of Health, including the Medicaid
12 program, and Insurance Department, and the Office
13 of the Medicaid Inspector General.

14 A question period will follow
15 each presentation.

16 We will begin testimony from the
17 Department of Health, Commissioner Richard
18 Daines.

19 And he will be followed by the
20 Medicaid Inspector General.

21 Joining us is our Vice Chair of
22 the Senate Finance Committee, Senator Liz
23 Kreuger, and my eminent specialist in health
24 care, who I would like to introduce himself.

25 ASSEMBLYMAN FARRELL: Good

1

2 morning, Senator.

3

4 I've been joined by Assemblyman
Hayes, who will introduce --

5

6 ASSEMBLYMAN HAYES: And on our
side, Mr. Chairman, thank you, we're joined by:

7

8

Assemblyman Mark Molinaro; and

Assemblyman Dave McDonough.

9

10 And a special hello and welcome
to the Members of the Amherst Youth Consortium
11 who are up in the back. Thanks for watching the
12 hearing.

13

14

SENATOR KRUGER: Good morning,

Commissioner Daines.

15

16

COMMISSIONER DAINES: Good

morning.

17

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Good morning, Senator Kruger,

Assemblyman Farrell.

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As I'm sure you've heard many
times this week, this is when New Yorkers are
facing financial difficulties and challenges, and
at the same time the State has to close a growing
budget deficit that is now estimated at \$8.2
billion.

25

We're trying to do in the

1
2 Department of Health executive budget whatever a
3 New York family is doing, provide what is most
4 needed while doing without the extras.

5 There are several themes that
6 run through all of the Department's budget
7 proposals for the new fiscal year.

8 First is always preserving
9 services that support the Department's core
10 mission of protecting and improving the public's
11 health;

12 Second, achieving reforms that
13 increase efficiency while maintaining quality and
14 access;

15 Improving accountability and
16 transparency;

17 Elimination of duplicative
18 services;

19 Consolidating, streamlining and
20 simplifying;

21 Flexibility to target resources
22 where they are needed most;

23 And, most importantly,
24 innovating to reduce the State's greatest public
25 health threats while at the same time controlling

1
2 the deficit.

3 We have a great opportunity this
4 year, despite the State's fiscal crisis, to have
5 a positive impact in the area of public health
6 and to show national leadership specifically on
7 the problem of obesity.

8 Overweight and obesity are now
9 challenging smoking for the infamous designation
10 as the top public health threat in New York.
11 Currently, about sixty percent of adults and
12 thirty-five percent of children and adolescents
13 in New York are obese or overweight.

14 The increase in overweight and
15 obesity is dramatically increasing New Yorkers'
16 risk of many chronic and debilitating conditions
17 including heart disease, diabetes, hypertension
18 and cancers.

19 Obesity shortens life spans with
20 the severely obese have a reduced life expectancy
21 up to twenty years.

22 I'll deviate from my prepared
23 remarks and comment about an article in the New
24 England Journal of Medicine I looked at last
25 night. It looked at the most overweight quarter

1
2 of children between five and ten and looked at
3 their subsequent life expectancy.

4 Beginning at about age thirty it
5 practically goes off a cliff, and every year
6 after that their life expectancy drops below that
7 of their normal weight peers.

8 Not only are the human costs of
9 obesity high, the health care costs related to
10 obesity are equally staggering. In New York an
11 estimated \$7.6 billion is spent every year to
12 treat conditions in adults related to overweight
13 and obesity, and much of that cost is paid by
14 Medicare and Medicaid.

15 The portion of State and Federal
16 taxes that go to pay for treatment of obesity-
17 related diseases is estimated at \$771 from every
18 New York household.

19 Several weeks ago I testified
20 before the State Senate Health Committee on food
21 policy and discussed Governor Paterson's obesity
22 prevention agenda.

23 The agenda includes:

24 Initiatives to increase exercise
25 among children;

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Improved nutrition;
Initiate calorie-posting
requirements in chain restaurants;
Banning the use of trans fats in
restaurants and food service establishments;

A ban on the sale of high
fat/high sugar junk foods in schools;

And a \$10 million revolving loan
fund to increase access to healthy foods in
underserved communities.

A key initiative of the obesity
prevention agenda is a proposed excise tax on
beverages containing large amounts of added
sugar. There is now a large body of scientific
evidence that sugar-sweetened beverages are the
single food group most strongly linked with
increased rates of obesity and risk for diabetes.

Per capita consumption of sugar-
sweetened beverages for American adults now
averages forty-six gallons a year, the equivalent
of forty pounds of sugar.

It requires an excessive amount
of exercise to burn off those calories which
otherwise are stored as fat.

1
2 Based on our experience with
3 cigarette taxes and the beverage industry's own
4 price elasticity models, this penny-an-ounce
5 excise tax would reduce consumption of sugary
6 beverages by an estimated fifteen percent.

7 As people replace sugary drinks
8 with diet sodas and non-sugar beverages,
9 including water and skim milk, we can make a big
10 dent in the obesity problem.

11 At the same time the sugar
12 beverage tax will raise much needed revenue for
13 public health programs and health services. Based
14 on a September 1st implementation date, the tax
15 is expected to raise \$465 million during the
16 first fiscal year and an estimated \$1 billion
17 over a full year.

18 Like the cigarette tax, the
19 revenue from the excise tax would go into the
20 health care reform pool to support health care
21 and other public health services. I can't think
22 of any other initiative that provides this
23 opportunity for a triple play. We will get
24 improved health for New Yorkers, reduced health
25 care costs and much needed revenue to support

1
2 health care services.

3 Tobacco, nevertheless, continues
4 to be New York's number one cause of preventable
5 disease and death. Health care costs related to
6 smoking-caused diseases approximate \$8 billion
7 annually. Our evidence strongly suggests that
8 cigarette packs' increases are the most effective
9 way to reduce youth smoking and encourage adult
10 cessation.

11 New York's \$1.25 increase on
12 this tax in 2008 was associated with increased
13 enrollment in our New York State Quit Line
14 Program, increased quit attempts, reduced
15 consumption of cigarettes and reductions in adult
16 and youth smoking prevalence.

17 Between 2007 and 2008, the adult
18 smoking rate in New York dropped from 18.9
19 percent to 16.8 percent. That's 310,000 fewer
20 smokers.

21 So this year's Executive Budget
22 proposes an additional \$1.00 per pack tax on
23 cigarettes, which would increase the State taxes
24 to \$3.75. This would restore us to have the
25 highest tax rates in the nation at this point.

1
2 We estimate that this will
3 result in 50,000 adults in the State quitting
4 smoking. It will prevent 100,000 youths under the
5 age of eighteen from becoming smokers. It will
6 decrease youth smoking by ten percent, and save
7 an estimated 48,300 New Yorkers from premature
8 death.

9 Over the next five years we
10 would save an estimated \$40 million in costs
11 related to smoking-related health problems.

12 The cigarette tax increase would
13 produce also an estimated \$200 million in annual
14 revenues again into the HCR pool to support
15 health care services, tobacco prevention and
16 control and other public health initiatives.

17 For example, the proposed tax
18 would allow for funding such measures as the
19 restoration of our anti-tobacco media funding of
20 \$10 million per year that was cut during the last
21 deficit reduction action.

22 Lead poisoning remains a
23 significant issue in many of our cities. Over the
24 past two years Governor Paterson has made a
25 commitment to end childhood lead poisoning in New

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York State once and for all.

We are making progress towards that. Childhood lead poisoning has fallen by seventeen percent in Upstate New York since 2005.

But there's more work to be done to eliminate the threat of lead for thousands of children living in older houses with lead-based paint.

To further efforts to eliminate lead poisoning as a public health threat to New York's children, the Governor's Executive Budget maintains support for the Childhood Lead Poisoning Primary Prevention Program.

We have other public initiatives in this budget.

Despite the very challenging crisis, the Governor's budget sustains the State's commitment to fighting the HIV/AIDS epidemic by providing statewide spending of approximately \$3.2 billion for HIV/AIDS programs, including \$120 million for the AIDS Institute.

Over the twenty-five years since the inception of the AIDS Institute, it has become important to restructure appropriation

1
2 lines to mirror today's epidemic and to maximize
3 programmatic effectiveness through continued
4 effective prevention and access to quality health
5 and supportive services.

6 So to achieve these goals, the
7 budget proposes the consolidation of multiple
8 individual appropriation lines into the following
9 comprehensive programmatic categories:

10 First, regional and targeted
11 HIV, STD and Hepatitis C programs;

12 Second, HIV, STD and Hepatitis C
13 prevention programs;

14 Third, HIV health care and
15 support services;

16 Fourth, clinical education; and

17 Finally, Hepatitis C programs
18 themselves.

19 This measure would give us the
20 flexibility to easily and quickly prioritize
21 emergent needs and would generate about \$3.8
22 million in savings. It also gives us
23 administrative efficiencies in the State Health
24 Department and also to community-based
25 organizations because there will be fewer

1
2 contracts and fewer Requests For Proposals to
3 manage.

4 The budget also focuses on
5 making our cancer services program more flexible,
6 efficient and responsive to current need.

7 Currently, the budget proposes
8 to consolidate fifteen unique appropriation
9 lines, and that would generate \$1.1 million in
10 savings.

11 We'll place emphasis on
12 screening, registry operations and survivor
13 support, and priority will be placed on evidence-
14 based interventions.

15 The general public health work
16 is our legislative mandate in Public Health Law
17 Article VI under which the State reimburses
18 counties for a defined set of public health
19 services and other activities.

20 This budget would eliminate
21 reimbursement for certain optional services that
22 we have determined are not core public health
23 activities.

24 The budget would transfer
25 funding of the County Medical Examiner Program to

1
2 the Division of Criminal Justice Services as much
3 of the work done by the medical examiners,
4 coroners and coroner physicians is criminal and
5 forensic in nature and aligns better with the
6 DCJS mission.

7 This budget would strengthen our
8 Early Intervention Program and help preserve
9 essential services for New York infants, toddlers
10 and their families. The budget proposes reforms
11 to the program that would make it more efficient
12 so we can continue providing early intervention
13 services to New York families.

14 These changes include a variety
15 of administrative actions that would require use
16 of preferred assessment tools, they would modify
17 speech eligibility standards, and revise
18 reimbursement rates.

19 In addition, the budget proposes
20 legislative actions that require providers to
21 bill Medicaid directly, to maximize commercial
22 insurance reimbursement, and it establishes a
23 sliding scale of early intervention parental
24 fees.

25 Turning to health care reform,

1
2 the Governor's Budget continues the historic
3 reforms achieved over the last two years. It
4 recognizes the critical need to protect the most
5 vulnerable New Yorkers and safety net
6 institutions that serve them. At the same time it
7 will slow the growth of Medicaid spending as we
8 continue to work towards achieving efficient
9 delivery of high quality, cost effective care.

10 Our efforts focus on achieving
11 greater efficiency without creating barriers to
12 enrollment for those eligible for Medicaid
13 services.

14 Despite all this, we continue to
15 rank first in the nation on Medicaid spending per
16 capita, twice the national average. And if left
17 unchecked, our Medicaid spending would have grown
18 to more than \$53 billion in the '10-'11 fiscal
19 year.

20 It's important to note that the
21 Governor also proposes to continue the State cap
22 on local Medicaid share. Recently, I attended a
23 meeting of local social services officials and
24 one made a point of saying how the Governor's cap
25 on the local share in his words had, quote, saved

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his county last year, end quote.

In New York, Medicaid is the single largest payer of health care. So if we can reform Medicaid, then we have an opportunity to leverage changes throughout the health care system.

And that's why over the last two years and in the proposed budget we are making important reforms to the Medicaid system because our Medicaid reimbursement system helps to shape the health care system of New York.

We continue reforms begun over the last two years to make the reimbursement rates more transparent and straightforward and to serve patients in the right setting at the right place.

We continue to emphasize rewards for improved quality of care.

Now, New York has a number of world-class health care providers, but our results in terms of quality and outcome are often mediocre. We should be getting better quality for the money we are spending.

We lead the nation in Medicaid

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inpatient hospital spending.

We rank fourth on per enrollee inpatient hospital spending, and twice the national average.

To roll back that spending and to better serve patients in the right setting at the right price, New York has invested more than \$600 million in improved outpatient care in the last two years.

This includes \$270 million in hospital outpatient programs, including clinics, ambulatory surgery, and emergency room.

It includes an increase of \$188 million in physician fees, \$128 million in other primary care settings, \$50 million in free-standing programs, and \$2.7 million invested in mental hygiene enhancements.

Another critical component of our historic health care reforms has been the updating of a decades-old hospital reimbursement system.

And we continue to address the problem of potentially preventable hospital readmissions, which are a source of extra expense

1
2 in the system. These readmissions occur because a
3 patient may be discharged too soon or because of
4 lack of follow-up care in the community.

5 In 2007, we found that more than
6 70,000 readmissions were potentially preventable
7 and these admissions cost \$813 million.

8 They're very costly in terms of
9 patient well-being as well. And the dollars we
10 spend on these patients would be far better
11 invested in services that keep the patient well
12 and out of the hospital.

13 The 2010-'11 budget proposes to
14 begin reducing funding for preventable
15 admissions, and in 2012 we would begin to
16 reinvest a portion of those savings in rewarding
17 the hospitals that reduce readmissions and
18 establish better post-discharge linkages.

19 This budget also funds an
20 additional hundred slots for doctors across New
21 York, fifty slots for physician loan repayment
22 and fifty slots for physician practice support to
23 improve access in medically underserved area of
24 the State.

25 The challenge in long-term care

1
2 same region. The current practice is irrational
3 and inefficient and drives up costs overall.

4 Similar to the reimbursement
5 method we just implemented for hospital inpatient
6 services, value-based regional pricing models for
7 nursing home care set a fair base price,
8 recognize legitimate cost differences among
9 providers, and take into account the acuity of
10 the patient the facility is serving.

11 We will continue to work with
12 the industry workers and consumers through the
13 Nursing Home Reimbursement Work Group to refine
14 this value-based regional pricing model.

15 Home care is the area of long-
16 term care for which the pattern of spending is
17 clearly unsustainable. From 2003 to 2008,
18 spending on home care increased by fifty-five
19 percent while the number of individuals served
20 decreased by twelve percent. Better management of
21 the reimbursement process is critical to bring
22 spending under control.

23 This budget will implement the
24 Certified Home Health Agency Episodic Pricing
25 Quality Model on January 1, 2012. This measure

1
2 will help to ensure that appropriate payment for
3 each patient is based on his or her needs.

4 As with nursing homes, we will
5 continue to work with stakeholders as we develop
6 the model.

7 The budget also proposes better
8 management and utilization of personal care,
9 which provides Medicaid-eligible individuals with
10 assistance with the activities of daily living:
11 bathing, toileting, grooming, eating, laundry,
12 meal preparation and housekeeping. These services
13 are ordered by a physician and based on a patient
14 need. The hours have been determined by local
15 social services districts following an assessment
16 of the recipients' needs in their homes.

17 Under the Governor's proposed
18 budget, individuals receiving personal care
19 services will be eligible for up to twelve hours
20 a day during this authorized period. This will
21 improve care while reducing costs.

22 Currently, there are
23 approximately 73,000 individuals statewide who
24 receive twelve hours or less of personal care.
25 And this will only affect the fewer than 5,000

1
2 individuals who receive more than twelve hours a
3 day of personal care.

4 Under this measure those
5 individuals would be eligible to move to certain
6 programs or alternative service providers where
7 their care can be managed and coordinated. Up to
8 three not-for-profit organizations would be
9 selected to assist those who need the transition.

10 Better coordination of care
11 benefits the individuals receiving services. They
12 would be assigned a care manager, receive a
13 comprehensive assessment of needs and obtain
14 assistance with medical appointments,
15 transportation, home care services, Medicaid
16 recertification and other services.

17 The State would realize \$30
18 million in savings through this better managed
19 personal care program.

20 This year's budget proposes
21 modest changes to continue to streamline the
22 eligibility process for health insurance programs
23 to ensure that eligible persons are able to get
24 and keep coverage.

25 Three years ago, we began a

1
2 process of tearing down the artificial barriers
3 that were keeping eligible people from enrolling.
4 This year's budget continues to help eligible
5 people get their coverage.

6 Since 2008, we've permitted
7 self-attestation of income and residency at
8 renewal for non-SSI-related Medicaid benefits and
9 for Family Health Plus members.

10 The proposed budget permits
11 Medicaid enrollees receiving community-based
12 long-term care also to attest to their income and
13 residency at renewal.

14 And the budget proposes to allow
15 the Department of Health to pursue a Federal
16 option called Express Lane Eligibility of
17 Children for Medicaid and Child Health Plus. As
18 the name suggests, Express Lane will allow
19 children to transfer between Medicaid and Child
20 Health Plus more easily and allow easier
21 enrollment of children already in receipt of food
22 stamps.

23 The implementation of a
24 statewide enrollment center is on track. A
25 contractor has been selected, and as soon as that

1
2 contract is approved, the implementation will
3 begin.

4 The enrollment center will
5 consolidate the Medicaid, Family Health Plus and
6 Child Health Plus toll free numbers to provide
7 one-stop shopping for persons already enrolled in
8 public health insurance and for those seeking
9 information about applying, and it will augment
10 the local social services districts by processing
11 telephone and mail-in renewals.

12 We're also very interested in
13 program integrity and Mr. Sheehan is here to talk
14 more about that. But we include a number of
15 proposals to strengthen the integrity of the
16 eligibility process. They include the use of tax
17 data to verify eligibility, selection of a vendor
18 to perform independent verification of assets,
19 and proposals to close certain loopholes related
20 to recovery.

21 The budget also includes
22 initiatives to help ensure that Medicaid pays
23 only for the appropriate use of services that are
24 needed.

25 These initiatives include

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2 measures to provide better management of physical
3 and occupational therapy services, non-emergency
4 transportation services in counties that are not
5 already managing that service, and managing
6 personal care services as I've mentioned.

7 These actions will ensure that
8 people get the care they need while at the same
9 time ensuring that our Medicaid dollars are spent
10 wisely.

11 Pharmacy costs are another major
12 cost driver in our budget. In this budget we
13 propose that State Medicaid spending on pharmacy
14 service will reach \$1.7 billion if we do not take
15 additional measures to control its growth.

16 The budget includes a number of
17 recommendations to control those costs. This
18 includes measures that will increase our rebate
19 revenue without affecting patient access to
20 medication. It proposes to collect supplemental
21 rebates on antidepressants, atypical
22 antipsychotics, antiretrovirals and antirejection
23 drugs. They will not be required to seek prior
24 authorization of these non-preferred drugs in
25 these classes and will not restrict access.

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2 Another action is to eliminate
3 the Medicare Part D drug RAB provided by our EPIC
4 program. We would discontinue Medicaid coverage
5 for antidepressants, atypical antipsychotics,
6 antiviral and antirejection drugs for dual-
7 eligible enrollees. These individuals are
8 eligible for both Medicaid and Medicare.

9 Medicaid has been currently
10 paying for this with State-only dollars even
11 though they are covered through the Federal
12 Medicare Part D program, which New Yorkers are
13 also paying for.

14 Since the inception of the
15 Medicare Part D program four years ago,
16 significant improvements have been made in that
17 program to assure access to critical drugs. That
18 program is now matured and caught up to our New
19 York State benefits, and there is no need for the
20 State to maintain the full Part D drug RAB.

21 This budget action would improve
22 care management by creating a single, complete
23 record of a patient's drugs in the Medicare Part
24 D program and will affect less than one percent
25 of the eligible population.

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2 Currently, seventeen of the
3 nineteen states with State pharmacy assistance
4 programs do not include a Part D RAB. And so our
5 program would mean that EPIC would no longer
6 cover drugs in classes already covered by
7 Medicare Part D. We would continue to cover
8 Medicare Part D co-payments and claims in that
9 donut hole of the Part D program and drugs that
10 fall in classes not covered by Part D -
11 barbituates and benzodiazepines.

12 Currently, more than eighty
13 percent of seniors in New York's EPIC program are
14 already enrolled in Medicare Part D. This budget
15 proposes measures that would require about 26,000
16 more seniors to enroll in Part D.

17 Most of those are seniors who
18 have already chosen a Medicare Managed Care
19 option but one that does not provide prescription
20 drug coverage even though an option with Part D
21 is available to them.

22 Their prescription drug costs
23 under EPIC are almost twice those of seniors who
24 have enrolled in the Part D plan.

25 The budget includes \$1.5 million

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2 to educate seniors about these changes and to
3 assist them in selecting the best Medicare Part D
4 program for their needs.

5 So, in conclusion, the ongoing
6 economic crisis challenges New Yorkers as never
7 before to maintain our commitment to health care
8 and health care reforms to serve a growing
9 population of unemployed individuals and to
10 continue to address the needs of the 2.7 million
11 New Yorkers who lack health insurance.

12 Governor Paterson has made
13 expanding coverage a priority and the State has
14 made great strides in extending coverage to the
15 most vulnerable New Yorkers through Medicaid,
16 Child Health Plus and Family Health Plus.

17 By streamlining eligibility we
18 can ensure that these individuals continue to get
19 health care services.

20 We continue our investments in
21 primary and preventive care through reimbursement
22 reform and focusing our core mission in public
23 health.

24 The budget proposals for long-
25 term care will help rein in spending while better

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managing patient care and services.

And we've made bold public health proposals to institute an excise tax on sugar-sweetened beverages to reduce obesity, generate funding for health care services and lower health care costs in the future.

We've also proposed an increase in tax on cigarettes which will have the same effect.

The health care proposals in this budget continue New York as a world-class health care system that is also accessible, affordable and of the highest quality.

Thank you.

I'd be very happy to answer any questions that you have.

SENATOR KRUGER: Thank you very much, Commissioner.

Questions.

Senator DeFrancisco.

ASSEMBLYMAN FARRELL: Before that, though, I'd like to mention that:

Assemblyman Gottfried, Chair of the Health Committee, has joined us;

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And Assemblyman Jef Dinowitz has
also joined us;

And Mr. Hayes.

ASSEMBLYMAN HAYES: And also
Assemblyman Jim Baccalles.

SENATOR KRUGER: Senator.

SENATOR DeFRANCISCO: Yes.

First, I'd like to ask about
Medicaid savings.

It seems to me that from
everything I've heard we spend more in Medicaid
costs than our next two states combined.

So it seems that if we are going
to cut education and other things and try to find
new sources of revenue, that we should really
look into how we could save money in the Medicaid
process.

Last year I asked you about -- I
forgot what the program is called, but when
someone - there's a Federal bill - when someone
goes to an emergency room, they cannot be turned
away, they have to be evaluated to make certain
that they have no emergency situation before they
are put back on the street.

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And we talked about the possibility of diverting many of those people to community-based clinics or the like.

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And if I recall correctly, you mentioned something about that there may be a possibility of a waiver from the Federal government to provide for an alternate system rather than going to the emergency room first.

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COMMISSIONER DAINES: No,

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there's no waiver from the Intala Program. Even at the height of the H1N1 crisis, there were great cautions about doing anything.

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Our approach really has been more to pull people away from the ER rather than push them out; in other words, to have the primary services that are more convenient and accessible and affordable, and people that don't need an ER will go there by choice.

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SENATOR DeFRANCISCO: And what

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has been done since last year's hearings to do that, to pull them away rather than push them out?

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COMMISSIONER DAINES: That's

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that whole series of investments in improved

1
2 primary and preventive services I talked about,
3 the things we're doing to improve the physician
4 supply in community so inner city and rural areas
5 have practicing physicians and patients don't
6 have to go to the emergency departments.

7 SENATOR DeFRANCISCO: And have
8 there been any definable savings as a result of
9 that process?

10 COMMISSIONER DAINES: Well, we
11 know that through the restructuring and, in many
12 cases, the downsizing of our acute care hospital
13 system, Berger and other, that when we have
14 removed ER capacity, that the actual -- the
15 services appear to be sought in non-emergency
16 settings about forty percent of the time.

17 That correlates with our figure
18 of about thirty to forty percent of ER visits
19 could go somewhere else.

20 So there are some successes
21 there, but we still have excess emergency
22 department utilization. And I think anybody in
23 hospital, in emergency care, would agree
24 hospitals are not seeking that. It's really the
25 patients don't seem to find good alternatives.

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SENATOR DeFRANCISCO: Well, are Medicaid patients or recipients able to -- are they instructed that there are alternatives? I mean is there some educational process going on right now --

COMMISSIONER DAINES: Yes.

SENATOR DeFRANCISCO: -- to encourage --

COMMISSIONER DAINES: As we enroll patients in managed care organizations, that's a large step, and our work on creating medical homes are exactly that, so that every patient has a medical home, either with a good physician's practice or a formal managed care organization.

And those are both -- there's a financial incentive to those organizations to keep patients in those medical homes. We're doing a major project across the Adirondacks, a medical home project, exactly that, to strengthen alternatives to ER care. And the hospitals are fully cooperative with that.

SENATOR DeFRANCISCO: And, for example, in Syracuse there's a Syracuse Community

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Health Center that's located very close to two major hospitals.

Have there been patients -- excuse me -- Medicaid recipients in our area, the Syracuse area, are they instructed, when they're on Medicaid, or if they're already on, are they given information that your first stop should be the Syracuse Community Health Center as opposed to the emergency room?

COMMISSIONER DAINES: That will be by their providers.

We've also built in an incentive into our Medicaid system so practices that offer extended hours - nights and weekends - there's a higher reimbursement rate.

And for practices in underserved areas there's a higher reimbursement rate.

SENATOR DeFRANCISCO: You said -- what is provided by the provider? The provider gives that notice to the recipient?

COMMISSIONER DAINES: I can't tell you specifically what, per pamphlet or anything, but it's a natural part of enrolling a patient in a medical home to say, well, you come

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here when you have non-emergent conditions.

SENATOR DeFRANCISCO: I guess my point is that I'm sure many, many Medicaid recipients would be more than happy to go to a doctor's office rather than the hospital at much less cost. And I'm just trying to find out what incentives there are or what information is provided so that these patients do that as opposed to just go automatically to the emergency room because that's what they've done for the last ten years.

COMMISSIONER DAINES: You know, you can do something with general education there. But I really think it's incentivizing the development of those medical homes and a reimbursement model that encourages physicians and managed care organizations to keep the patient home.

SENATOR DeFRANCISCO: But the patient is going to make the first choice; correct?

COMMISSIONER DAINES: True.

SENATOR DeFRANCISCO: And if the patient is ingrained in a system that's

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2 always allowed him or her to go to an emergency
3 room, no matter what the incentives are, the
4 patients won't necessarily volunteer, voluntarily
5 change that pattern of behavior.

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7 And it seems to me that it would
8 be relatively inexpensive for them to be somehow
9 instructed that that's the first place they have
10 to go, not that they can go, but they have to go
11 unless it's an emergency.

12

13 COMMISSIONER DAINES: Well,
14 again, we cannot under the Intala rules make an
15 absolute requirement that someone doesn't go to
16 the ER. And it's not as simple as simply
17 instructing patients.

18

19 These are middle-of-the-night
20 situations and, again, it's a problem. It's not
21 as simple as simply issuing instruction.

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23 SENATOR DeFRANCISCO: Except
24 I'm sure that there are emergency room visits in
25 the middle of the day as well.

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27 COMMISSIONER DAINES: Yes.

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29 SENATOR DeFRANCISCO: Would you
30 grant that?

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32 COMMISSIONER DAINES: Oh, yes.

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SENATOR DeFRANCISCO: All
right.

So if you slow down the
emergency room patients going to the emergency
rooms during the day because they now are
instructed that they have to go to a community-
based center if it's not an emergency, you're
saying that's against the Federal law?

COMMISSIONER DAINES: I agree
with the goal. The means are not only
instruction. You have to do a lot of things.

The Federal law is that when
people appear in an emergency department, they
have to be evaluated and stabilized.

SENATOR DeFRANCISCO: Okay.
So -- I think this is
approximately where we were last year.

And what I'm trying to get at is
that you got to change habits of people, not
incentives for -- if there's incentives, they
have more primary care facilities and the like.

If there's some already
available during the broad daylight but patients
know they're not going to be turned away at the

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hospital -- if they're informed and it's stated in no uncertain terms, because we are running out of money in the State of New York for many things that we need to do and we are taxing everything that walks and some that doesn't, that you have an obligation, if it's not an emergency, to go to this place during the day.

Now, what is so radical about that and why can't --

COMMISSIONER DAINES: I don't -

-

SENATOR DeFRANCISCO: -- that

be done?

COMMISSIONER DAINES: --

disagree with the instruction.

SENATOR DeFRANCISCO: Okay.

And do we do it?

COMMISSIONER DAINES: I don't

do it specifically. I don't think our program hands people a piece of paper that says that.

SENATOR DeFRANCISCO: Well,

when people enroll for Medicaid, do they have to go talk to somebody somewhere to enroll?

COMMISSIONER DAINES: They pick

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a managed care provider in most cases.

And, again, the whole managed care environment, including discrete instructions, is to come here with your non-emergent conditions.

SENATOR DeFRANCISCO: And you're saying that's a matter of practice presently?

COMMISSIONER DAINES: Of our managed care organizations and our medical homes, absolutely.

SENATOR DeFRANCISCO: And do patients have to reapply for Medicaid from time to time?

COMMISSIONER DAINES: Yes. We talked about the renewal process.

SENATOR DeFRANCISCO: And how often do they have to go back in?

COMMISSIONER DAINES: Generally every twelve months, but I think it varies with sub-populations as well.

SENATOR DeFRANCISCO: Well, I'm not an expert in this area. But it seems to me that habits have to be changed, and the only way

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2 to do that is to make sure recipients understand
3 they have an obligation. And although they can't
4 be turned away from an emergency room, I don't
5 know what other penalties can be done in order to
6 make certain that they do what they're supposed
7 to do so we don't have to keep paying more in
8 Medicaid than the rest of the world.

9 So I would hope that in the
10 cost-cutting approaches you would give that some
11 thought. I think I mentioned that last year too.
12 But apparently we're basically where we were.

13 I noticed in your prepared
14 remarks you indicated about doing some studies or
15 trying to analyze the non-emergency
16 transportation that's provided in Medicaid; is
17 that correct?

18 COMMISSIONER DAINES: That's
19 right.

20 SENATOR DeFRANCISCO: Okay.
21 What are the steps that you
22 intend to take? Because there was an article in
23 our paper, but I've been crying about this for a
24 long period of time, that, you know, when people,
25 for example, in the City, who have a great mass

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2 transportation, are allowed to take taxicabs to
3 non-emergency medical and dental appointments,
4 that seems to be ripe for a possibility of saving
5 some money.

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7 In our paper it just came out
8 recently from some of the ambulance services that
9 people are actually calling in the ambulance to
10 get rides to their doctor because they need
11 somebody to talk to, but not emergency
12 situations. And it's an extremely big expense.

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14 So what is the remedy that you
15 got in mind to try to avoid some of the abuse of
16 the transportation dollars that are spent?

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18 COMMISSIONER DAINES: I'll ask
19 Donna to explain some of this.

20

21 Donna Frescatore is our Director
22 of the Office of Health Insurance Programs,
23 Medicaid.

24

25 MS. DONNA FRESCATORE: Thank
26 you. Good morning.

27

28 SENATOR DeFRANCISCO: Could you
29 use the mike, please.

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31 MS. DONNA FRESCATORE:
32 Certainly.

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2 Our plan is to select one or
3 more contractors to assist in arranging
4 transportation for individuals. The goal would be
5 to ensure that the right mode of transportation
6 is used, to ensure that it's quality
7 transportation, that it's timely, that there's
8 program features that ensure that patient was
9 actually present and given a ride.

10 About thirty counties in the
11 State currently do that. And this would augment
12 their efforts.

13 SENATOR DeFRANCISCO: How about
14 saying no to the taxi ride? I mean I don't know
15 that that -- it's kind of simpleminded, but --

16 MS. DONNA FRESCATORE: No. I
17 think --

18 SENATOR DeFRANCISCO: -- if the
19 taxi driver --

20 Maybe the first time you get the
21 bill and you pay it and then maybe notify the
22 taxi service that this is not going to be
23 permitted any longer.

24 MS. DONNA FRESCATORE: The way
25 we envision this program would work and in the

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2 way some of the programs in some of the counties
3 throughout the State that have transportation is
4 that, other than public transportation, taxi
5 rides would need to be prior approved.

6 SENATOR DeFRANCISCO: Prior
7 approved?

8 MS. DONNA FRESCATORE: Prior
9 approved, based on the patient's need.

10 SENATOR DeFRANCISCO: Then how
11 does someone get -- the one instance that they
12 were reporting is one individual called an
13 ambulance twenty times in Onondaga County --

14 COMMISSIONER DAINES: Well,
15 once again, this --

16 SENATOR DeFRANCISCO: -- and
17 got it paid for.

18 COMMISSIONER DAINES: -- this
19 is not about ambulance calls.

20 Again, the call between a
21 patient and an ambulance service is not something
22 that we can jump in the middle of and do a prior
23 approval on.

24 SENATOR DeFRANCISCO: Okay.

25 COMMISSIONER DAINES: It's

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dangerous for patient care.

SENATOR DeFRANCISCO: Okay.

An ambulance service where it's proven time and time again that it was not an emergency situation, how do you --

COMMISSIONER DAINES: Again, I just don't know of a way that you can blacklist certain patients that can't call. There will be sooner or later a tragedy that results.

SENATOR DeFRANCISCO: So we can't legislate some type of responsibility on behalf of people; we just got to keep going no matter what they say, they're entitled to whatever they want?

COMMISSIONER DAINES: Well, again, you're distinguishing between emergency ambulance calls and these routine transportation needs which we fully intend to manage.

SENATOR DeFRANCISCO: Well, let's stay on emergency. I'll get back to cabs in a minute.

But with emergency, with an ambulance situation, there were instances where people would actually call the ambulance and get

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their carrier to pay them for the ambulance and not reimburse the ambulance company for the service.

And obviously in many instances the ambulance -- this was a very good way to make a few extra bucks. And the ambulance service has to make a determination whether to bring lawsuits against people that don't have any money.

I mean is there some remedy for that type of situation so that people --

COMMISSIONER DAINES: Well, I think that may be more a Jim Sheehan problem than a -- it sounds like fraud to me.

INSP. GEN. JAMES SHEEHAN: If I could, Senator, --

I'm Jim Sheehan.

SENATOR DeFRANCISCO: I don't think -- is your mike on?

INSP. GEN. JAMES SHEEHAN: There we go. Much better.

I read the same story in the Syracuse paper and I think that there are three different things going on here.

The first is the story that you

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just referred to, which is that people are getting reimbursement by their private insurers, that doesn't come -- that's a private insurance issue. And I know Troy Oechsner will be here later to address it from that side.

The second issue is --

SENATOR DeFRANCISCO: May I stop you a moment?

INS. GEN. JAMES SHEEHAN: Sure.

SENATOR DeFRANCISCO: Doesn't Medicaid pay for those types of services as well?

INS. GEN. JAMES SHEEHAN: Medicaid does pay for those services, but we don't send a check to the recipient.

SENATOR DeFRANCISCO: Okay. Thank you.

INS. GEN. JAMES SHEEHAN: The second set of issues has to do with how do you determine actual emergency.

And I know in some states the legislature has given that power to the Medicaid program. That has not been the case here. And, in fact, New York State law requires the ambulance to go. If they get the call, it requires the

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ambulance to go to that location because the difficulty is how do you judge when it's a true emergency and when it isn't.

SENATOR DeFRANCISCO: Do any states have a system whereby they don't automatically -- or they go to the patient and find out there's not an emergency and they don't have to transport them?

There's got to be some state that has some kind of common sense approach to absolute abuse here I would think.

INS. GEN. JAMES SHEEHAN: All I know about this particular issue is what I saw in the paper, which is that Pennsylvania apparently has a system which imposes a limitation on those trips.

But that's something we could certainly look into and get back to you, Senator.

SENATOR DeFRANCISCO: Well, yeah.

I think -- I guess my point is each one of these areas seems to be ripe for some unique way of, whether it's transportation, whether it's emergency room visits, whether it's

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2 what -- some states, other states pay a lot less
3 than we do in Medicaid and that are just as big,
4 if not bigger, like California.

5 And it seems to me we want to be
6 as humane and wonderful as we can. But if we find
7 situations where there are abuses, those should
8 be automatic to try to find out how other states
9 have dealt with it, and not every year, well,
10 we'll look into it, or we think -- somebody must
11 have heard of this type of situation somewhere in
12 the institutional wisdom of the Health
13 Department.

14 And I hate adding more taxes and
15 I won't add more taxes when there are ways to cut
16 situations.

17 Let me ask another question of
18 the Doctor, Dr. Daines.

19 Personal care, you're talking
20 about limiting the number of hours to twelve
21 hours of personal care. And I've asked many
22 witnesses about this.

23 Personal care in the State of
24 New York, the dollars that are spent, at least --
25 the last numbers I think for 2007, was \$1.9

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2 billion with a "b" for New York City, \$390
3 million for the rest of the State; \$1.9 plus
4 billion for New York City, \$390 million for the
5 rest of the State.

6 Now, in looking at those
7 numbers, Mayor Bloomberg and others have said,
8 well, we've got more people that are undocumented
9 - illegal immigrants I guess what they really are
10 - that are in the country, that we have to take
11 care of.

12 And what we do -- and we also
13 have more people and we have more problems and
14 more serious.

15 The fact of the matter is when
16 you look at the personal care numbers, the hours
17 that are allowed in New York City are more than
18 twice the amount of the hours that are done in
19 the rest of the State.

20 Now, if we want to take into
21 account many, many different things and we give
22 New York State twice -- New York City, which is
23 about half the population, twice what the rest of
24 the State gets, give them \$750 million or \$800
25 million, you could save \$1 billion right there.

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There's got to be something that makes that happen.

And have you -- you must be aware of these numbers. Have you looked into why that happens in New York City?

COMMISSIONER DAINES: Well -- and, again, in my prepared testimony I addressed at least beginning to cap the number of hours, transition patients into more effective programs and to manage that and rationalize the reimbursement.

Our problem in long-term care is that each sector has grown. There was always the promise that investment in one sector would replace spending in another. And we've seen each of the sectors grow, and again regardless of whether we were serving an increased number of patients.

So we share the problem. And that's why we proposed those controls in the budget.

There's always a question could we do more and faster. But that is the direction that we're going.

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2 SENATOR DeFRANCISCO: I don't
3 think the people in Upstate New York are any less
4 humane to people who need personal care. All
5 right?

6 And if one region of the State
7 is so far out of whack and is providing many,
8 many more hours at a much, much greater cost, and
9 is spending four times what the rest of the State
10 is spending, I would think there's got to be a
11 reason for that and there ought to be someone at
12 some point that sees that. Don't just say cap
13 everybody, but take a look at how we could
14 provide the same type of services that are
15 provided to the rest of the State in New York
16 City at a comparable cost.

17 Now, is there something wrong
18 with that logic?

19 COMMISSIONER DAINES: This is -

20 -

21 SENATOR DeFRANCISCO: This is a
22 regional issue.

23 COMMISSIONER DAINES: --
24 exactly the logic we're implementing. I don't
25 know why you're protesting me. We said the first

2 thing to go after is people that are receiving
3 more than twelve hours. That is not a good
4 investment of public funds. And whether they're
5 Upstate or Downstate, let's go after that group
6 of people, place those 5,000 individuals in
7 alternative arrangements which are much more cost
8 effective. So we're going after it.

9 But there's no single action
10 that rectifies that whole situation. You have to
11 do it piece by piece.

12 SENATOR DeFRANCISCO: Well,
13 what is the cause of that imbalance?

14 COMMISSIONER DAINES: Increased
15 numbers on the services, individuals getting more
16 hours on the services, and sometimes payment
17 rates for whatever those services are. Those
18 combination of things always drive health care
19 costs.

20 And if there are regional
21 imbalances, the costs will be higher in one
22 region.

23 SENATOR DeFRANCISCO: Four
24 times the cost?

25 COMMISSIONER DAINES: Well, we

1

2 see vast differences in various things across the
3 State like that.

4

SENATOR DeFRANCISCO: So after
5 the twelve hours are used up, then other type of
6 services are provided?

7

COMMISSIONER DAINES: Managed
8 long-term care or transition and diversion
9 waivers. There's a lot of ways to better look at
10 that high utilization population.

11

SENATOR DeFRANCISCO: I guess
12 my point would be there is no rational -- there's
13 no reason that I can think of that people are so
14 different in the City of New York that they need
15 twelve hours plus additional services beyond
16 that. Those hours are uncapped, is that the
17 problem?

18

COMMISSIONER DAINES: There's
19 not been a cap and we are instituting a cap and
20 alternative services. So we're implementing I
21 believe exactly what you're suggesting.

22

SENATOR DeFRANCISCO: A twelve-
23 hour cap; correct?

24

COMMISSIONER DAINES: That's
25 one of our actions in personal care.

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SENATOR DeFRANCISCO: And after
the twelve hours what cap is there on the
remaining services that people get?

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COMMISSIONER DAINES: You mean
those under the twelve hours or the twelve-hour -

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-
SENATOR DeFRANCISCO: Over.
Over.

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COMMISSIONER DAINES: They go
into one of our managed programs which are
essentially capped. They're incentivized programs
so that there's a given amount of money for the
service and the managed care organization manages
it effectively.

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And that's been -- in many cases
our best approach to health care costs in general
is that kind of a managed care arrangement.

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SENATOR DeFRANCISCO: Have you
looked at what Upstate New York and Long Island
and the Hudson Valley and the rest of New York,
have you looked at what they do to act much more
efficiently than the City and kind of implement
what they do?

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COMMISSIONER DAINES: We looked

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2 intensively at the regional differences and even
3 differences within regions. And in home care and
4 personal care that is why we came up with the
5 proposals that we did, to start to bring that
6 back into alignment.

7

SENATOR DeFRANCISCO: And those
8 proposals will be equally applied to both Upstate
9 and New York City?

10

COMMISSIONER DAINES: Yeah.
11 There -- it will be an even playing field, and if
12 the effect is more or less in one area it's
13 because they're already adhering to those
14 standards.

15

SENATOR DeFRANCISCO: And do
16 you need legislation to have that done?

17

COMMISSIONER DAINES: I'm
18 getting a yes from my folks. That's legislation.

19

SENATOR DeFRANCISCO: And why
20 is that? Is the legislation that we have now just
21 open-ended, that there are no limits?

22

COMMISSIONER DAINES: Mark.
23 Mark Kissinger, Office of Long-
24 Term Care.

25

MR. MARK KISSINGER: Good

1

2 morning.

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The current benefit authorized in the law is an open-ended benefit. That's correct.

6

SENATOR DeFRANCISCO: Okay.

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So why is it in Upstate New York there's many, many less hours that are provided than in New York City?

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What are they -- if they want more hours for the patients, I would think that there would be an incentive for that patient to get those hours that they want. There's no cap.

14

MR. MARK KISSINGER: Yes.

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There's numerous reasons for the regional difference in personal care authorizations done by the local social service districts.

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21

Each social service district has to authorize the care. So the county is the one that authorizes the level of --

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23

SENATOR DeFRANCISCO: Could you speak in the mike, please.

24

25

MR. MARK KISSINGER: Yes.

Each social service district has

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2 to authorize the number of hours that an
3 individual recipient gets.

4 SENATOR DeFRANCISCO: Bingo.

5 Okay.

6 Why don't you implement in New
7 York City that same process that is implemented
8 in the rest of the State, to keep those hours
9 consistent?

10 MR. MARK KISSINGER: The way the
11 law reads, Senator, it's an open-ended benefit
12 and it gives the discretion to the local social
13 service district to set the level and the
14 duration of the service.

15 We've worked with the City of
16 New York over the last fifteen/twenty years on
17 their personal care spending over -- in relation
18 to the rest of the State.

19 There are many reasons why the
20 long-term care system is different in different
21 parts of the State.

22 SENATOR DeFRANCISCO: And they
23 authorize more hours?

24 MR. MARK KISSINGER: They do.

25 SENATOR DeFRANCISCO: And

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there's no disincentive of doing that; correct?

MR. MARK KISSINGER: No. With the enactment of the Medicaid cap on the local districts any incentive to control costs in personal care went away frankly.

SENATOR DeFRANCISCO: I missed that last comment.

MR. MARK KISSINGER: When the Legislature enacted the cap on local spending for Medicaid, there's no incentive or disincentive to control personal care authorizations or even --

SENATOR DeFRANCISCO: Okay. Let me just kind of go back down memory lane.

All the counties were dying for a cap on Medicaid spending because it was breaking their budgets because they have to pay fifty percent - correct? - of the cost; is that right? Am I right so far?

COMMISSIONER DAINES: Yes.

SENATOR DeFRANCISCO: I'm talking to Mark right now.

Is that correct?

MR. MARK KISSINGER: Yes,

1
2 roughly. I mean there are different -- percentage
3 shares were different depending on the types of
4 services that were there.

5 SENATOR DeFRANCISCO: Okay.

6 So now in our infinite wisdom
7 the State of New York, in order to give relief
8 that the counties thought that they were getting
9 from this onerous burden, we take the cap off so
10 that -- I mean we don't require the counties to
11 share in the costs for amounts above a certain
12 figure, whatever they were at that time; correct?

13 MR. MARK KISSINGER: That's
14 correct. There's a three percent growth rate.

15 SENATOR DeFRANCISCO: All
16 right.

17 So at least for the short term
18 all these counties were gloriously happy of the
19 fact that they were not paying the cost, as
20 greater share as they were in the past, because
21 the share keeps going down. What is it? About
22 thirty-seven percent now?

23 MR. MARK KISSINGER: I don't
24 know the particular share. We can get back to you
25 on that.

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SENATOR DeFRANCISCO: Okay.

But what happens is it means more and more costs to the State of New York because there is no incentive whatsoever to limit the number of hours or who is getting what because - and this is the Legislature's fault - because the counties don't have to pay for this increase; fair enough?

MR. MARK KISSINGER: That's correct. The local share is limited to a growth rate of three percent.

SENATOR DeFRANCISCO: All right.

So your twelve-hour limit is your effort to try to deal with that issue; is that fair to say?

COMMISSIONER DAINES: Well, yes. Remember, these services have to be ordered by a physician based on patient need. So there is always the threat of rescinding or not paying for services that don't meet those standards. That's different from whether they're qualified or not.

SENATOR DeFRANCISCO: How many of those recisions have there been in the last --

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COMMISSIONER DAINES: Well,

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that -- Mr. Sheehan will talk about that. But six

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hundred million of that style of recovery.

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SENATOR DeFRANCISCO: Okay.

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All right. I have one other

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area. I don't want to go -- other people have

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questions.

9

One other area: the sugar tax.

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COMMISSIONER DAINES: Yes.

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SENATOR DeFRANCISCO: The sugar

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tax you're justifying on the basis of a fight

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against obesity; correct?

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COMMISSIONER DAINES: That's

15

right.

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SENATOR DeFRANCISCO: All

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right.

18

Now, is it fair to say in your

19

medical opinion that there's a lot of people that

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drink sugared soda that aren't obese?

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COMMISSIONER DAINES:

22

Certainly, yes.

23

SENATOR DeFRANCISCO: All

24

right.

25

So by an obesity tax what we're

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2 doing, without even getting into the issue of
3 jobs and companies losing business, you're
4 actually requiring people who make right choices
5 in life - they may not be obese because they work
6 out or they might not be obese because they drink
7 in moderation - you want them to pay the same tax
8 in order to fight the obesity of those who make
9 other choices?

10 COMMISSIONER DAINES: The
11 correlation between sugared beverage consumption
12 and obesity both for children and adults is so
13 tightly connected that in a sense the tax scales
14 itself very well, that it's the heavy users, the
15 heavy over-consumers that have the obesity
16 problem, and they would be paying the taxes and
17 having the behavioral changes.

18 SENATOR DeFRANCISCO: So should
19 we have a tax on supersized double cheeseburgers
20 with fries?

21 COMMISSIONER DAINES: Sugared
22 beverages are really just sugar and water.
23 They're truly empty calories. And I think that's
24 a good target for a tax approach.

25 As you get into snack food, fast

1

2 food, junk food, these are complex. And I think
3 the Governor's proposal for calorie posting is a
4 better approach than trying to get into the
5 individual components and quantities in other
6 foods.

7 But soda is water and sugar,
8 empty calories, and it's a very pure target for
9 that kind of a tax.

10 SENATOR DeFRANCISCO: Isn't
11 what people eat a matter of choice?

12 COMMISSIONER DAINES: Well,
13 it's a matter of choice. But the problem is the
14 market is mispricing sugared beverages. The price
15 of a sugared beverage doesn't include the
16 subsidies that we give to the corn and sugar
17 producers and it doesn't include the downstream
18 costs of obesity and health care.

19 And, frankly, if the price -- if
20 sodas were not mispriced, if we weren't
21 introducing moral hazard into this, you could let
22 the market work.

23 But the market is failing on
24 soda.

25 SENATOR DeFRANCISCO: And where

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did you get your doctorate in economics?

COMMISSIONER DAINES: I studied like anyone else. And if you want to look at the economic models, you can.

But that's the way pricing --

SENATOR DeFRANCISCO: Are we pricing in the price of double -- supersized double cheeseburgers the various factors as far as subsidies to people who raise beef or people who grow potatoes or whatever the components are of that meal that people choose to have and it affects their health?

COMMISSIONER DAINES: I know you can provide complications and red herrings. But, again, this is an issue that's ripe. It's ready. It's focused on a single agent that is highly correlated with obesity.

SENATOR DeFRANCISCO: Are people morbidly obese because in many cases because they don't get exercise?

COMMISSIONER DAINES: Exercise probably contributes in the neighborhood of twenty percent of the obesity problem with excess calories in the eighty percent range. It's mostly

1

2 overconsumption. We all consume more than we did
3 thirty years ago.

4 SENATOR DeFRANCISCO: Should we
5 tax people who don't exercise?

6 COMMISSIONER DAINES: Again,
7 I'm saying it's a minor contribution, and I don't
8 see a model that would work there.

9 SENATOR DeFRANCISCO: And
10 twenty percent is minor in your opinion?

11 COMMISSIONER DAINES: It's
12 certainly not the eighty percent that
13 overconsumption contributes.

14 SENATOR DeFRANCISCO: Do you
15 agree with the approach that insurance companies
16 have where they give a free health membership if
17 you buy their insurance so to encourage people to
18 make the right choices and to try to stay in
19 shape rather than be morbidly obese?

20 COMMISSIONER DAINES: There's a
21 lot of incentives that you can put in favor of
22 those kind of behaviors and I think that's
23 excellent.

24 Certainly with our subsidized or
25 fully subsidized health insurance models in our

1

2 Department of Health - Medicaid - we're not able
3 and we wouldn't get a friendly audience to
4 implement something like that.

5

SENATOR DeFRANCISCO: But are
6 you -- I'm not talking Medicaid now, because it's
7 not only the Medicaid recipient that's going to
8 be taxed on the sugar. I'm just asking you
9 whether you agree with that concept.

10

COMMISSIONER DAINES: In
11 concept. But I'm also very concerned about
12 insurance mandates, that every time we mandate
13 something else from an insurance company, we
14 drive up the cost across the board.

15

SENATOR DeFRANCISCO: Well,
16 there are insurance companies that are doing it
17 now that aren't mandated.

18

COMMISSIONER DAINES: Again, if
19 they make it as a good business decision, that's
20 terrific.

21

SENATOR DeFRANCISCO: Okay.

22

But you're in favor of that good
23 business decision?

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COMMISSIONER DAINES: I would
25 like to see their models, is it a good business

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2 decision.

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SENATOR DeFRANCISCO: Why don't we get right to the problem as opposed to trying to go indirectly through tax on this or no tax on that or you determining what the economics of things are or the Legislature making it.

Why don't we -- I got to ask you one thing first.

Do people on Medicaid, for example, are they entitled to an annual physical?

COMMISSIONER DAINES: Annual physicals are not really a standard in health care anymore.

SENATOR DeFRANCISCO: So the answer is no?

COMMISSIONER DAINES: So they are entitled to necessary services. The concept of an annual physical in most stages is no longer a recommendation.

SENATOR DeFRANCISCO: Okay.

Why don't we just tax people that are morbidly obese?

A VOICE: I take exception to that.

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(Laughter.)

SENATOR DeFRANCISCO: I'm saying we want to get to this goal where we want to stop obesity. We want to stop obesity.

And in many instances there's things beyond people's control. But I'm talking about morbid obesity.

COMMISSIONER DAINES: So, Senator, you would say that the thirty-five percent of children who are overweight or obese and highly overrepresented in minority and low-income populations, the answer is more taxes there?

SENATOR DeFRANCISCO: I guess my point is -- don't play the minority card with me because it ain't going to work.

My point is simply this. If obesity is what we are trying to correct, to me it's a shotgun approach to charge people taxes who are not morbidly obese.

I went to the gym this morning. It's a pain in the neck every morning to go out for an hour. I'd rather sit on my couch and eat some chips and watch television.

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But I have made certain choices
in my life. And I could drop dead tomorrow from
something else.

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But the fact of the matter is
that it offends me to provide taxes, to use taxes
as a means to try to control behavior, and you
are the one who chooses what taxes that you think
are important to change people's behavior.

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If the problem is obesity,
there's got to be a way to put a tax on an
insurance policy if you're morbidly obese,
require certain things to be done, that if you're
on Medicaid, that one of the rules is you got to
exercise now and then if you're morbidly obese.

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Isn't that -- doesn't that
directly arrive -- or let me give you a better
one.

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If we give stamps for food
stamps and people can use those food stamps
wherever they want, we want to fight obesity, why
don't we use our money a little bit better? Why
don't we provide that these food stamps are for
only certain foods that are wholesome, they have
nutritional value and they are going to help that

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2 little kid, the poor little minority kid that
3 you're concerned about?

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5 Because the only choices that
6 are going to be had for those food stamps are
7 good choices. Wouldn't that be a more direct
8 approach?

8

9 COMMISSIONER DAINES: We've
10 done that with programs like WIC where we can
11 control the food availability. There are people
12 looking at the Federal food stamps program and
13 starting to advocate for exactly those things.
14 Again, it's one of those Federal policies that
15 has to be looked at.

15

16 But I agree about steering
17 people towards good choices.

17

18 SENATOR DeFRANCISCO: Well,
19 what policies could we in the State implement
20 that move more towards dealing with the problem
21 directly?

21

22 COMMISSIONER DAINES: Well, I
23 think our improvements to the Women, Infants and
24 Children Nutrition Program was an excellent one.

24

25 Our other departmental hunger
prevention programs go exactly along those lines.

1

2 We provide vouchers for people to get fresh
3 fruits and vegetables in farmer's markets to
4 supplement the food package.

5 SENATOR DeFRANCISCO: Could the
6 State of New York be a leader in a movement with
7 the Federal government to push for a program
8 that's not just with WIC but the overall food
9 stamp program if we're really concerned about
10 obesity?

11 Isn't that a much more direct
12 and more effective approach than the pick and
13 choose whatever the beverage of the day may be or
14 whatever the food stuff of the day may be and tax
15 that in an ad hoc manner?

16 COMMISSIONER DAINES: The one
17 doesn't preclude the other.

18 To rationalize this whole food
19 market all the way from farmer subsidies on
20 downstream I think would make a great deal of
21 sense, and I think we'd love to participate in
22 that.

23 But at the same time we have an
24 opportunity here for a triple play: reduce
25 obesity, save health care dollars, and generate

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some money for the health care system.

And I don't see a better opportunity in this year to accomplish something.

SENATOR DeFRANCISCO: And a quadruple play: to tax people that don't have the problem that you're trying to rectify.

So I guess I probably made my point. But my point is that we should be dealing directly with the issue, not just justifying another increase in cost to people that is based upon choices that they didn't make. Maybe they made the good choices and they are being penalized even though they made the right choices. And they're eating the right foods. But they are paying for people who have the opportunity to eat junk and get obese and to have their children see them obese and eat junk.

So I think that we've got to have a major restructuring. If that's what the Health Department is concerned about, obesity, we should be doing that. We should be guaranteeing that kids are exercising in school rather than -- I don't know what they do in gym nowadays.

But the fact of the matter is

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2 those are the policies that I would be looking
3 for, not a tax based upon the pretext of a
4 problem because it's not -- I don't believe the
5 cause and effect is as direct as we could be if
6 we used other approaches.

7 Thank you.

8 COMMISSIONER DAINES: Thank
9 you.

10 SENATOR KRUGER: Thank you,
11 Senator.

12 My Assembly colleagues are going
13 to be here through much of the presentations.
14 However, many of us are going to have to go over
15 to the Senate that's going into session very
16 shortly.

17 So I'm going to take license for
18 a moment, if I may, Mr. Chairman, and since we're
19 talking about health issues, is smoking good for
20 you?

21 COMMISSIONER DAINES: Is that a
22 question?

23 SENATOR KRUGER: Yeah, that's a
24 question.

25 COMMISSIONER DAINES: I'll give

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2 you the answer. No.

3

SENATOR KRUGER: No.

4

5 So now we want to put -- the
6 Executive Budget puts a tax, an additional tax on
7 cigarettes.

7

COMMISSIONER DAINES: That's

8

right.

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10 SENATOR KRUGER: And that's a
11 dedicated tax that would go towards filling our
12 health care gap.

12

COMMISSIONER DAINES: That's

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right.

14

15 SENATOR KRUGER: At the same
16 time we have probably about - oh, I don't know,
17 because the numbers are floating in the air - but
18 maybe, let's say, forty million packs of
19 cigarettes floating out there with no tax at all.

19

Do you think that's a good

20

thing?

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COMMISSIONER DAINES: No,

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Senator.

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24 I thought you would probably
25 address this. And I have to -- I'm not an expert
on tax and Native Americans. And I won't be able

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to answer your questions about it.

SENATOR KRUGER: Okay.

So I guess for the record what we should reflect is that while we are looking to tax those that, additionally those that already pay tax on cigarettes, what we would be doing indirectly is driving more people to buy untaxed cigarettes as it becomes more expensive to buy taxed cigarettes. That's just a logical assumption that I'm making.

I would hope that the health officials in this State, as well as the Governor, recognize that if we were to dedicate all of the money that could be driven towards health care and dealing with many of the health care ills that face our State today and the nation, by using the proceeds that would be easily achievable, we could virtually fill our current void and look for a sustaining pot of money that we would be able to use in the outer years.

So while we're trying to tax New Yorkers to death with nickels and dimes and a penny on a sugared beverage - and then we'll have to decide what's sugared and what's not sugared -

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2 and probably drive a new layer of contraband,
3 untaxed soda and fruit juices into that
4 marketplace.

5

6 The next thing we have to do is
7 look at candybars. They're not good for you
8 either. And they have a lot of sugar in them. And
9 maybe we should start taxing that as well. And
10 then we'll have contraband candybars.

11

12 So at the end of the day I think
13 that the message that is resonating through this
14 whole Capital is that we have to collect, before
15 we cut anyone, before we do anything to any sick
16 folks or to failing hospitals and nursing homes
17 and we try to retool home care, is that we should
18 be collecting what could be well over \$1 billion
19 worth of contraband that has become an illegal
20 enterprise in this State.

21

22 And it's a sad comment that we
23 want to nickel and dime taxpayers of New York to
24 death while while we're sitting here today we're
25 losing millions of dollars of taxpayer revenue
that could be going towards filling all of the
voids that we are talking about today.

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Thank you.

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ASSEMBLYMAN FARRELL: Thank

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you.

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Next to question will be Mr.

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Gottfried, Chairman of the Health Committee.

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ASSEMBLYMAN GOTTFRIED: Good

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morning.

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I think my only criticism of the

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beverage tax is that I'd make it higher if I

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could. It's a smart, carefully targeted, easy to

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implement tax that not only produces revenue from

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something that nobody really needs to purchase.

13

It's basically a recreational item for which

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there are ample alternatives that society would

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be better if people turned to those alternatives.

16

It's about as smart a policy as

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one could come up with. And I don't know whether

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we are going to be able to enact it this year,

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but I certainly hope we can.

20

I've a couple of questions.

21

There are many proposals at the

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State level and there are more being talked about

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being advanced at the Federal level to try to do

24

various pilot programs and whatnot to promote

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change in the way we deliver health care,

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2 promoting medical homes, promoting better disease
3 management, care management, promoting the
4 formation of integrated health systems and the
5 like, all of which I think are enormously
6 important, have terrific potential for both
7 improving outcomes and controlling costs.

8 They all, however, require
9 considerable leadership and time and staff effort
10 from the State Health Department in order to get
11 organized and designed and implemented.

12 And at this stage the Health
13 Department, primarily because of budget concerns,
14 has been losing top staff, has been losing
15 funding for contracting out for outside
16 assistance for running this kind of program.

17 And my question is: what has
18 been the effect of those staffing and resource
19 limitations on the Department on New York's
20 ability to implement and design more of those
21 models of health care delivery reform, whether
22 it's medical homes or integrated systems or other
23 things?

24 COMMISSIONER DAINES: Well,
25 first, in terms of leadership, we've had some

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2 retirements in that. We have had such strong
3 leadership in the Department that without missing
4 a step we realigned a few people behind me and
5 moved on very well.

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There are across the whole
government -- any properly run business is
limiting their staff, and we had to do that.

When we come and say we need to
consolidate funding streams so that we can be
more efficient, by doing fewer small contracts,
it's about using the staff we have effectively.

I didn't get into it but our
Patient Safety Institute and our NYPORTS program,
can we reduce the number of reports we receive so
that we can more efficiently turn around a good
report on a smaller number of significant items.

And those are the kind of things
that we do to react, and we work smarter because
we just frankly know we won't have more people.

We are strained. When something
unexpected, like H1N1, comes along, people just
simply move to twelve and eighteen-hour days, and
you would be amazed the amount of time people put
in on that. And it's a terrific department there

1

2 and we are doing just the best we can within the
3 limits of the staff that we have.

4

I will sound our drum a little
5 bit. In certain areas that the Federal government
6 is now moving into and saying we ought to do
7 this, for example, health information technology,
8 for example, medical home creation, for example,
9 comparative effectiveness, we've already been
10 there and plowed the ground.

11

We are doing medical homes in a
12 number of places.

13

We established an Office of
14 Health Care Information Technology Transformation
15 years ago and put the heel monies into it that
16 you provided.

17

We have the best comparative
18 effectiveness studies in cardiac services in the
19 world come out of our cardiac services group and
20 Ed Hannon. And it's kind of fun to watch these
21 terms come up in Washington as if they're new
22 inventions. And we've already been doing them
23 here.

24

ASSEMBLYMAN GOTTFRIED: But if
25 you were -- if instead of -- I mean it took an

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2 enormous investment of your time and several
3 other people's time in the Department to get the
4 Adirondack Medical Home Program up and running.
5 And I think that was a magnificent success.

6 If you were trying to do a dozen
7 of those programs in the coming year or twenty of
8 them, even if you and Donna and Foster Geston
9 work fifteen-hour days, I don't see how we've got
10 the current quantity of staff to be able to do
11 all of that.

12 COMMISSIONER DAINES: Well, I
13 know you're trying to hand me a bouquet or
14 something, but, you know, --

15 ASSEMBLYMAN GOTTFRIED: Well,
16 no.

17 COMMISSIONER DAINES: -- but,
18 you know, it's kind of like --

19 ASSEMBLYMAN GOTTFRIED: I'm
20 trying to lay the groundwork for handing you some
21 resources.

22 COMMISSIONER DAINES: -- when
23 they asked Abraham Lincoln how long a man's legs
24 should be, he said long enough to reach the
25 ground.

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And how much staff should we have? Enough to reach the ground we stand on.

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And we're in the same limits that everybody else in this State has.

6

ASSEMBLYMAN GOTTFRIED: I want to talk about the twelve-hour personal care thing. And I try not to call it a cap because I don't think it really is a cap. I think it's a different way of getting to more than twelve hours of care if that is what you need and to make sure that that is what you need.

13

And I think the concept of using things like the Long Term Home Health Care Program or Managed Long Term Care programs as a way to manage those high utilization cases makes terrific sense.

18

I think there are a lot of technical issues and mechanical issues that we need to deal with before we enact it.

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But I'm puzzled by the \$30 million savings figure.

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If there are about 5,000 of those cases, I think my arithmetic is right, the \$30 million in savings would mean saving \$6,000

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per case. And I don't see how you could do that.

COMMISSIONER DAINES: Mark.

MR. MARK KISSINGER: The way we approached the fiscal estimates on the personal care changes were a lot of different puts and takes.

For example, we thought that people at sixteen hours of care may go back down to twelve hours of care and not go into the other programs, therefore saving that four hours of care.

We also thought people over that could be better managed. So there will be reductions in hours of service.

However, as you say, it's not -- it will be done on an individual basis by individual assessments through the programs that they go to.

So it's not just a strict 5,000 people divided by \$30 million. There's also the spending on the \$1 million for the non-profits to help with people transitioning from the fee-for-service personal care program to the other managed programs.

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So there's a lot of different moving parts. And we can brief you fully on those at a different time.

ASSEMBLYMAN GOTTFRIED: Okay.

I think that's all I wanted to ask right now.

Over the next couple of weeks we'll be asking a lot more. But that's it for today.

Thank you.

ASSEMBLYMAN FARRELL: Senator Hemp Hannon.

SENATOR HANNON: Thank you, Mr. Chairman.

Good morning.

We'll see if we can get this to work.

Thank you for being here.

I want to start off by in a sense following up on what Assemblyman Gottfried said and appreciate the work that so many people in the Department have done especially in H1N1. This hearing could well be about that if you hadn't done such a good job.

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2 So let's hope we anticipate for
3 the next ground.

4 There's a number of things I
5 could mention. And if the Senate Republicans, as
6 may be likely, get involved in actually doing
7 part of this budget, unlike last year where we
8 were excluded, but at some point there has to be
9 a budget in the State, then there's going to be a
10 lot of things I'm going to have points to make:
11 eating disorders, arthritis, Red Cross, the EPIC
12 changes, poison control, penalizing counties.

13 So those are all there which
14 this will give us an opportunity for discussion,
15 including the question of how do you get \$70
16 million out of restricting premiums on health
17 care systems, a degree of mathematics that I've
18 never -- I can't even approach to appreciate.

19 But I wanted to talk about two
20 things.

21 One was where are we going with
22 the system. You had mentioned we keep on
23 addressing specific areas of health care even
24 within, say, the silo of long-term care, and yet
25 every time we do something, we don't find savings

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in another arena but we get growth in what we've addressed.

And I think it's because we do not approach the budgeting or the programming as a dynamic process. We keep looking on one specific, and then we don't really appreciate what we are going to have to do for the resulting changes in the other arenas.

And that's especially, I think, apropos this week as we see the Governor having made two emergency loans to St. Vincent's Hospital in Midtown Manhattan from, I presume, the restructuring pool.

Where are we going with all of these cuts to hospitals, nursing homes, home health care?

Where is the system going to take us?

Government is great at regulating. But if we cut off the supply of money -- we have purported these great budget deficits this year. I'm told that we have equally as much of a deficit next year and the year after.

What do we do and what process

2 do we put in mind, in place, to start thinking
3 about how these health care providers survive?
4 What can be done?

5 I don't know that we've done
6 anything looking out for the future. We've made
7 changes. You came up with the APG system to move
8 costs from inpatient to ambulatory. But that was
9 a step that wasn't a whole system.

10 And I don't expect you to --
11 you've done really well at grasping this whole
12 complex financial system the State has. But I
13 don't expect you to have it off the top of your
14 head. I want to pose that as a problem that we
15 collectively face to where we are going with the
16 health care system in this State.

17 So --

18 COMMISSIONER DAINES: Well,
19 I'll just -- you know, we do have an overall
20 concept.

21 Some of this came out of both
22 the need and what the Berger Commission did. And
23 if you remember, the Berger Commission said it
24 was about restructuring bricks and mortars
25 primarily. But it really ended with a call to do

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two more things.

They said you absolutely have to invest in primary and preventive care services and you have to rationalize the reimbursement system.

And if you look at what we are doing, we are investing in primary and preventive services and improving them and we are rationalizing the reimbursement system.

And we are trying to walk and chew gum at the same time. We are rationalizing hospital reimbursement. We are rationalizing nursing home reimbursement and we are addressing home care and personal care so we don't have that phenomenon that we squeeze one and the other one bulges as we've seen with institutional long-term care versus personal care and home care. We are working on those things.

And meanwhile we're trying to build the information infrastructure that we need so that we really can make the whole system work much better. And that investment is going on.

Yes, there are individual crises and problems that break out and you deal with.

2 But everyday we're working on reimbursement
3 reform, primary and preventive services, and a
4 much more intelligent infrastructure for the
5 whole health care system.

6 SENATOR HANNON: Good points.
7 But I still think we're not totally prepared --

8 COMMISSIONER DAINES: Oh, I
9 would agree with you, Senator, yes.

10 SENATOR HANNON: A couple of
11 other things.

12 One is I would love to get a
13 report, and I know it's probably not something
14 that's required, but of what happened to all the
15 money from the so-called pools that were created
16 in the '09-'10 budget, the hospital pools. I'd
17 like to see how this worked.

18 COMMISSIONER DAINES: Somewhere
19 back here is Bob Reed.

20 SENATOR HANNON: Well, I would
21 just like to get it on paper. We could put
22 everybody to sleep, more so than they are now.

23 The last point I want to make is
24 the rhetoric and -- you know, I know you get
25 handed a lot of things to carry for Budget and

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2 you get handed a lot of things to carry for the
3 Second Floor.

4 We've already had the discussion
5 and it's on websites about our -- my view of the
6 soda tax, which is not positive.

7 But one of the rhetoric pieces
8 that comes up is we spend more per capita on
9 Medicaid in New York State. And no one ever
10 explains that we also have Medicaided the entire
11 mental health system, which California has not.

12 But as long as this rhetoric
13 continues, and I really wonder why are we
14 continuing to do all the, quote, streamlining. We
15 had six or seven ease of eligibility, for
16 increase in Medicaid eligibility, in the last
17 budget. There's more in your testimony. We say we
18 do more easing of eligibility.

19 We have the statewide enrollment
20 center which calls into question where we leave
21 the counties in the decisionmaking process.

22 And in one point you even say
23 that we're going to have mail-in renewals.

24 You know, we can't have it both
25 ways. We can't give out this benefit and then

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restrict the oversight on the benefit.

And we've had something like two million new New Yorkers on Medicaid in the last several years. No wonder it costs the most in the nation. We just have this dichotomy of how we are going to approach it. And I don't think we've come to grasp as to how we put controls on it.

COMMISSIONER DAINES: Well, you know, our growth in Medicaid enrollment has been driven, certainly over the last eighteen to twenty-four months, by the near collapse of the national economy and the rise in unemployment rates.

I'll remind everyone --

SENATOR HANNON: Not entirely, Doctor.

COMMISSIONER DAINES: -- it's those high unemployment rates --

SENATOR HANNON: Not entirely.

COMMISSIONER DAINES: No.

SENATOR HANNON: We did.

COMMISSIONER DAINES:
Principally. And those unemployment rates are what triggered the higher FMAP money that comes

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2 into the State. So you don't get one without the
3 other, not that we wouldn't rather have lower
4 unemployment.

5 But all of the streamlining that
6 we're doing - and I'll leave it to Mr. Sheehan --
7 what we try to do is say where there is fraud,
8 improper enrollment abuse, duplication, we need a
9 program integrity system that prevents that.

10 But where we're simply putting
11 up hurdles in front of eligible people to enroll,
12 it makes no sense because those are the people
13 that come back to the emergency department, that
14 don't get preventive care, and come back on our
15 bad debt and charity care pool. And we can pay
16 for it today or pay for it tomorrow. But those
17 people don't go away.

18 SENATOR HANNON: I know they
19 don't go away.

20 We did seven or eight increases
21 in eligibility last year. We took away the face-
22 to-face interviews. We took out the interaction.
23 We did not increase Medicaid managed care the way
24 we ought to have done.

25 Mr. Sheehan has certainly a

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2 herculean task in order to recover things.

3 The point is, though, you can't
4 have an administration - and whether it's Pataki
5 or Spitzer or Paterson - complaining about the
6 high cost of Medicaid on one hand and then
7 opening the doors on the other hand.

8 So we have to figure this out.
9 It's not partisan. But it's governmental, and the
10 people in this State deserve a better answer.

11 It's not just you. It's all of
12 us.

13 And, by the way, the cap that
14 you reference in your testimony that causes a
15 local health official to say it saved a lot of
16 money was a cap that the Legislature initiated
17 and was put in place several years ago before
18 this administration, and it should be a tribute
19 to the Legislature putting the cap on and
20 continuing to have innovation in the Medicaid
21 system.

22 Thank you, sir.

23 ASSEMBLYMAN FARRELL: Thank
24 you.

25 Assemblyman Hayes.

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ASSEMBLYMAN HAYES: Thank you,
Mr. Chairman.

Commissioner, thank you for your
comments and your testimony this morning. You
have a very difficult job and I think you do it
very well and I commend you for what you do.

I want to get back to the issue
of Medicaid fraud. And I know we're going to hear
from the Inspector General after your testimony
about efforts to recoup money that has already
gone out the door in Medicaid fraud.

And we read these outrageous
stories in the press. We look at the specific
examples that Comptroller DiNapoli talks about
when he does his audit, including his most recent
audit at the end of December that talked about
the Dutchess County woman and the daily \$300
taxicab ride, and the total \$169 million that he
saw as being wasteful or fraudulently spent.

My question really is, in spite
of all the efforts to try to get that money back
once it's already out the door, what is the
Department doing in terms of the process that it
puts in place to make sure that that money isn't

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2 expended in the first place, it doesn't even
3 leave out the door before the Inspector General
4 has to get involved and there is either a Federal
5 inquiry or there is a referral from the Attorney
6 General or there is a prosecution that comes as a
7 result of the effort of the Inspector General.

8 What is the Department doing to
9 do a better job to make sure that that money
10 doesn't go out the door in the first place?

11 COMMISSIONER DAINES: We're
12 investing and upgrading in our legacy systems of
13 eligibility and payment in MEDNY and others. So
14 that there are huge systems that take a long time
15 to replace, but we're in the process of replacing
16 and upgrading those.

17 The current system or the new
18 systems we can ratchet down what are called
19 edits. So when we see something that doesn't
20 match - fifty cavities in one mouth or something
21 like that - no payment goes out and maybe a
22 referral goes over.

23 So a lot of it is that kind of
24 work.

25 When, either through the

1
2 Comptroller or by other means, we learn of an
3 individual outrage, like that Dutchess County
4 case, what you see us come back with is a
5 program. So when you see our transportation
6 management program that we just described, it's
7 driven by understanding that we still have
8 problems like that and saying let's manage it
9 upfront.

10 And so we do react to those
11 things both by building integrity into the system
12 and then, when we have a breakdown, not just kind
13 of saying, well, that's awful and we are
14 embarrassed, but designing something that we can
15 do about it.

16 And those are some of the
17 programs I've presented to you today.

18 ASSEMBLYMAN HAYES: You know,
19 there have been allegations in the press, and I
20 know there is an ongoing Federal investigation
21 right now, and so maybe you will need to be
22 careful about how it gets commented on, but we've
23 read about the allegations about what's happened
24 at the Research Foundation and what the Federal
25 government is looking into.

2 There has been some removal of
3 personnel at Buffalo State College in Buffalo
4 where I'm from. And these are some investigators
5 who seem to be looking into whether or not the
6 State Health Department was kind of looking the
7 other way in terms of this expenditure that goes
8 out of Medicaid because, of course, the Federal
9 match that it attracts.

10 I wonder if you would comment
11 about those kinds of allegations.

12 COMMISSIONER DAINES: I can't
13 comment on the specific case. That's not a policy
14 and that's not a practice. Again, if we find
15 something like that, we will focus on it. But
16 never policy, never a practice that we would
17 tolerate.

18 ASSEMBLYMAN HAYES: Certainly
19 clerical errors, things that are done by mistake,
20 happen anywhere. We're human beings and we hope
21 that technology is there to help cover some of
22 those human errors. But even technology can make
23 a mistake.

24 COMMISSIONER DAINES: And I've
25 been on the provider end too and I have sympathy

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with our good hospitals and clinics and those who serve and bill billions of dollars of Medicaid and are concerned about when they billed improperly. I have sympathy for them as well.

ASSEMBLYMAN HAYES: And that's where I'm going with my next question.

Essentially what we hear back from many of the honest providers is that, you know, there have been mistakes that have been made, there have been clerical errors, and then when subject to an audit, there is almost extortion-like attempts to recover that money when those mistakes are extrapolated over the course of a number of months or years.

Maybe that's a question I --

COMMISSIONER DAINES: I don't want --

ASSEMBLYMAN HAYES: -- should put directly --

COMMISSIONER DAINES: -- because it's a loaded term, I don't want to say I'm handing it to Jim. But maybe that's something that he wants to talk about.

ASSEMBLYMAN HAYES: Yes. And

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I'm sure he will.

But I want to, in the context of my question to you, say that it doesn't make much sense if we are not putting in -- you know, every year we ask the same question and we're being told, you know, well, we're doing a better job, we're getting referrals that come back and we try and tighten up.

But is there any way that you can assure us that there are specific policies or plans that are being put into effect and can you quantify that at all?

Because we know what the damage is that is being done. We just had the Governor last week say that the deficit has blown up since he presented his budget to the Legislature by \$750 million.

Speaker Silver, who is usually much more optimistic about the revenue coming to the State, says he's probably \$250 million short. It's probably more like \$1 billion.

And the question really comes back to, in a program, a Medicaid program, that most experts say has inherently ten to thirty

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percent waste, fraud and abuse factor, even if you took the low end of that scale of ten percent in our program, that's almost \$5 billion in a State that has a \$8 billion current budget deficit.

It seems to me that there's got to be more assurance from the Department and a way to quantify what are the cost savings that you are realizing in the Medicaid program.

COMMISSIONER DAINES: Well, I think the most accurate estimates about what is preventable or recoverable would come to what we are able to put in the fraud and abuse recovery.

You know, we're investing across the board in systems and people to build integrity into it. And I'd far rather not pay a dollar out, rather than pay it out and see if Jim can get it back later. We're all agreed on that.

But I will say, if you say there's going to be \$5 billion come out of the health care economy supported by New York State, you've got a lot of providers that wonder really where does that \$5 billion come from.

ASSEMBLYMAN HAYES: And it

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2 seems to always be -- the big arrow always is
3 pointed where it's coming from after the fact,
4 after the horse has left the barn, when either
5 the Inspector General or the Attorney General or
6 the Federal government comes back and does an
7 audit or brings, you know, a proceeding and
8 points to where it is.

9 It never seems to be that the
10 Department can quantify to us what are you
11 catching on the front end and what new system,
12 what new data mining expertise for claims
13 processing --

14 COMMISSIONER DAINES: Well,
15 you're asking something a little bit difficult.
16 You're asking us to quantify things we didn't do.
17 In other words, all of the proper payments that
18 we've done are what we are doing there.

19 I can't say, well, there was an
20 improper payment and then I blocked it at the
21 door. Our system is -- it is our proper payment
22 system.

23 ASSEMBLYMAN HAYES: You can't
24 say that?

25 COMMISSIONER DAINES: And then

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2 Jim finds six hundred and what?

3 INS. GEN. SHEEHAN: Five hundred
4 two.

5 COMMISSIONER DAINES: \$502
6 million that we --

7 ASSEMBLYMAN HAYES: So you
8 can't point to any examples where you've said,
9 we, ah-hah, we've caught a payment that should
10 not go out and we've stopped it.

11 COMMISSIONER DAINES: Everyday
12 our edits catch these.

13 ASSEMBLYMAN HAYES: Well,
14 that's what I'm talking about.

15 COMMISSIONER DAINES: I don't
16 know, Donna, can you say what we are catching on
17 our edits? I mean it's a constant --

18 ASSEMBLYMAN HAYES: That's what
19 I'm talking about, yes. We're trying to get that
20 quantified.

21 MS. DONNA FRESCATORE: Thank
22 you.

23 We have, as you know, thousands
24 of edits in the e-menu, which is the claims
25 payment system for Medicaid.

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2 And many of those edits reports
3 the number of claims that have been captured by
4 that edit and value them.

5 We worked hand-in-hand with the
6 Medicaid Inspector General, Mr. Sheehan's staff,
7 to develop more edits over the course of the past
8 year. I think it's fair to say thousands of edits
9 have been implemented.

10 They do things like identify
11 home care that's billed when someone is in a
12 nursing home, for example.

13 Or as Dr. Daines mentioned, too
14 many -- an unreasonable number of dental services
15 in one visit.

16 So those are in place.

17 We also have staff that do pre-
18 review of certain services: durable medical
19 equipment, which I think you know, nursing
20 services, private duty nursing services, and some
21 requests for some other services.

22 We are able to report what those
23 savings are. Those are really cost avoidance.

24 ASSEMBLYMAN HAYES: And are you
25 able to report specifically a dollar amount for

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what that cost avoidance or what that cost savings is, and do you report that anywhere?

MS. DONNA FRESCATORE: We report it internally. But I don't believe it's in any of the prepared testimony.

ASSEMBLYMAN HAYES: It would be very interesting to me if we could get some information about that.

MS. DONNA FRESCATORE: We'll be happy to gather that.

ASSEMBLYMAN HAYES: One final question.

You know, Senator Kruger at the Transportation hearing yesterday grilled the Director of the MTA about allegations that there are some 23,000 free Metro cards that are out in circulation that are being used by employees or employee family members in riding the system.

Yet the State Comptroller in his audit indicated that they found 25,950 Medicaid recipients had more than one identification number.

It's those kinds of things that boggle my mind that the Department was not able

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to put in any kind of control on the front end to the issuance of multiple numbers, to the tune of 25,950 individuals.

How does something like that happen? And do we not become aware of it until the State Comptroller audits the program and finds that out?

COMMISSIONER DAINES: Some of the things - and I can't speak to that specifically - actually the Comptroller duplicates findings that we're already aware of.

In other cases, again, when we prevent a problem, it's really not reportable. All of the requests, if it comes in for a second Medicaid number, that we are able to reject it at the local or the State level. I don't have a number on that.

ASSEMBLYMAN HAYES: Okay. Thank you very much.

ASSEMBLYMAN FARRELL: Thank you, Mr. Hayes.

Assemblyman Baccalles.

ASSEMBLYMAN BACCALLES: Hello, Commissioner.

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2 Let's start with the easy one,
3 the sugary drinks.

4 In deference to my colleague,
5 the Chairman of the Health Committee, in Upstate
6 New York that's not going to be easy to implement
7 simply because of the number of not only fast
8 food restaurants but other restaurants that put
9 in self-service type machines where you buy a
10 drink, and whether it's a fruit drink, whether
11 it's a diet soda or whether it's a sugary soda,
12 it all comes out of the same thing.

13 And so what's going to happen in
14 those cases is the restaurant's just going to
15 raise the price of everything. They're not going
16 to know whether you get a regular coke or whether
17 you get a diet coke or whether you get a Hi C
18 lite that has virtually very little sugar in it.

19 How are we going to -- this is
20 going to be something that's going to be an
21 absolute nightmare and just going to raise the
22 cost of drinks, especially in the Upstate areas
23 where this tends to be more prevalent than in the
24 Downstate.

25 COMMISSIONER DAINES: Well, I

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don't know of the prevalence issue.

You know, I suppose industries, they can sort of try to avoid or evade the public health goal we've set here. But I think -- I'd rather see these good businesses say let's see if we can cooperate and achieve the public health goal and then work through any particular situation.

Remember, it's an excise tax on the syrup. So the actual production as it works its way along the production and sales line, that will be a more expensive product.

And, again, a business that makes a decision to spread it across everyone may be in a competitive disadvantage to another one who says let's let the public health effect take place and make sure that the tax is applied to the more expensive product.

I personally wouldn't want to pay a tax on something where it's not the product that we're trying to tax.

ASSEMBLYMAN BACCALLES: Well, I mean if you look at the price, especially at fast food restaurants, that's where they make their

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2 money is on the soft drinks. They basically trade
3 off the meal, the fries and everything else, and
4 they get you to -- if you buy all three in a
5 package, because you're talking about a canister
6 of soft drink that, you know, is mixed with soda
7 water and comes out of a machine. And the profit
8 margins are huge.

9 A lot of local churches rent
10 these machines in some of the events that they
11 have and a cup of soda that you would pay, you
12 know, in a restaurant \$1.50 for, \$1.25, cost that
13 restaurant roughly three or four cents.

14 COMMISSIONER DAINES: Well,
15 you're making my point that these products are
16 mispriced. They don't reflect the real cost of
17 the product to society.

18 ASSEMBLYMAN BACCALLES: Yeah.
19 But that's -- enough said.

20 Under cancer services you talk
21 about the budget proposed to consolidate fifteen
22 unique appropriation lines, it would save \$1.1
23 million.

24 What are we doing? I mean --

25 COMMISSIONER DAINES: Well, and

1
2 again, that kind of got to Mr. Gottfried's point
3 about when you got limited staff, how can you
4 make it more efficient. And where we have
5 multiple individual lines, we have to have
6 staffing and procedures and RFPs and contracts.

7 What we're doing is
8 consolidating those into broad lines of
9 prevention and education and provider support.

10 We are making some economies
11 both on the administration of the programs and
12 then just the overall reductions we've had to
13 make because of the budget.

14 But we're deliberately not at
15 this point saying what lines will get what amount
16 because we would defeat the proposal, which is to
17 provide some flexibility to our program
18 administration.

19 We'll always favor things that
20 have an evidence base that serve underserved
21 populations and we'll favor direct supportive
22 services to those populations rather than more
23 remote items such as provider education and
24 research.

25 ASSEMBLYMAN BACCALLES: Okay.

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2 Under general public health work
3 it says this budget would eliminate reimbursement
4 for certain optional services that we've
5 determined not to be core public health services.

6 Are these optional services ones
7 that the State went in or local governments went
8 in, or --

9 COMMISSIONER DAINES: These are
10 county services.

11 The best example my staff
12 brought to me was certain laboratory services
13 which are really billable to private -- they're
14 laboratory tests on individual patients, billable
15 to providers, things like that that really
16 shouldn't be paid out of the public health
17 budget, that we're no longer including those as
18 optional services. There are other optional
19 services that certainly continue.

20 ASSEMBLYMAN BACCALLES: Okay.

21 So that these are services that
22 counties have chosen to provide on their own?

23 COMMISSIONER DAINES: From a
24 menu of options they've chosen those, and there
25 is enormous variability across different

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2 counties, do different things.

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4 So we looked at that and said
5 let's focus on core public health goals and these
6 sort of random other things we will not make
7 optional services anymore.

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9 ASSEMBLYMAN BACCALLES: Home
10 care; and I know Senator DeFrancisco did touch on
11 it, elaborate on it.

12

13 Is there a look -- I mean, if
14 someone is eligible to be in a nursing home, they
15 meet that criteria as far as the care that they
16 need, but they choose to stay home, is there a
17 lookback for home care?

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19 COMMISSIONER DAINES: A what?

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21 ASSEMBLYMAN BACCALLES: A
22 lookback. Do they look back and ask that's five
23 years, like they do if they went into a nursing
24 home?

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26 COMMISSIONER DAINES: I still
27 didn't catch the question.

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29 ASSEMBLYMAN BACCALLES: Okay.

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31 If someone is Medicaid eligible,
32 is there a five-year lookback if they choose home
33 care versus institution?
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COMMISSIONER DAINES: I'm

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getting a no there.

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ASSEMBLYMAN BACCALLES: So

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could that be part of our problem?

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I mean if someone is eligible --

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excuse me -- if someone is eligible to be in a

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nursing home, they meet the criteria as far as

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level of care that they have to be in a nursing

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home, they passed a little test, and yet they

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choose -- you know, the family gets together and

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says, oh, my God, we have a plan, got all these

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assets, quite frankly, let's do home care for

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five years so we can basically, you know, dispose

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of these assets and then they become nursing home

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eligible, go in and the five-year lookback is

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there.

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If someone is Medicaid eligible

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for a nursing home and they choose to do home

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care, with no lookback period, I can kind of

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understand why someone would use round-the-clock

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care in a home situation because they can then

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dispose of their assets.

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COMMISSIONER DAINES: You know,

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I mean I appreciate your point.

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I mean our basic problem with long-term care in New York - and this really goes to what's the real cost driver of why Medicaid in New York is so expensive, it's because our Medicaid program pays for so much of long-term care. I think seventy percent of nursing home care is paid for by Medicaid.

So, in essence, we've made long-term care a middle class entitlement. And the only way to pay for that is to somehow get those resources out of the middle class, either by going after resources or taxing.

And that's really what we're caught in. And the Lieutenant Governor and others are pointing that out on a national level, that that dual eligibility, the elderly that get acute services from Medicare but are Medicaid for their long-term care, custodial type services, are one of the things that's really breaking the budget in states like ours where we have provided that as a benefit.

ASSEMBLYMAN BACCALLES: And yet when someone goes in a nursing home, the reimbursement to that nursing home for caring for

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2 that patient really is responsible for pushing up
3 private pay rates because -- you know, my mother
4 was a private resident in a nursing home. The
5 difference between what the Medicaid rate was for
6 someone in that home versus private pay was
7 substantial.

8 And all that really did was
9 drive people that were private pay to Medicaid
10 earlier than they would have been.

11 I mean roughly -- there was, I
12 think, a disparity of about \$25,000 a year
13 between private pay and what Medicaid pays for
14 nursing home care.

15 COMMISSIONER DAINES: It's our
16 classic dilemma. On the one hand, we're spending
17 too much on Medicaid, and on the other hand we're
18 not paying enough with Medicaid, and we're always
19 trying to square that circle.

20 ASSEMBLYMAN BACCALLES: I think
21 that gets back to the question that Senator
22 Hannon had.

23 We have not reduced or said,
24 okay, if, you know, if you're Medicaid eligible,
25 these are the services that you are eligible for.

1
2 We really haven't -- even though we've cut
3 Medicaid expenditures year after year after year,
4 starting way back with even Governor Pataki, even
5 before that, but yet we haven't asked our health
6 care providers, you know, you don't have to do as
7 much. You don't have to cover these individuals.
8 These people are no longer going to be eligible
9 for the program.

10 All we've really done when we
11 cut Medicaid is cut the reimbursement to the
12 providers themselves, and in some cases we can do
13 efficiencies that will make it work okay, but in
14 other cases we're just putting -- we are going to
15 end up putting a lot of these health care
16 providers out of business.

17 COMMISSIONER DAINES: Well, I
18 think the providers can answer what the effect of
19 removing people from Medicaid would be.

20 In my experience in a hospital
21 is the patients came back through, if anything
22 else, a different door of the hospital with the
23 same need. And at best I'm on the bad debt and
24 charity care or complete charity care system.

25 ASSEMBLYMAN BACCALLES: I know.

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2 But my point is that the more we
3 cut reimbursements, all we're really doing is
4 asking those same providers to do the same
5 service, same level of service, for less money.

6 You know, in New York City
7 where, if a hospital closes, people literally
8 walk around the block and go to another one, in
9 Upstate New York if a hospital closes, we drive
10 twenty or thirty miles to go to the next one.

11 And that's a concern that a
12 number of us have. Or instead of driving thirty-
13 five miles to see a loved one in a nursing home,
14 you may drive sixty or seventy miles to see a
15 loved one in a nursing home.

16 So that's a concern that I have
17 with respect to, you know, some of the cuts that
18 we are seeing not only this year but in previous
19 years.

20 Thank you.

21 ASSEMBLYMAN FARRELL: Thank you
22 very much.

23 We've been joined by Deputy
24 Speaker Earlene Hooper and Assemblyman Spano.

25 ASSEMBLYMAN HAYES: And

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2 Assemblyman Boyle on this side. Thank you.

3 ASSEMBLYMAN FARRELL: The next
4 to question, Mr. Dinowitz.

5 ASSEMBLYMAN DINOWITZ: Good
6 morning, Commissioner.

7 I had a couple of questions for
8 clarification on the issue of EPIC.

9 Right now, all EPIC enrollees
10 are currently required to enroll in a Medicare
11 Part D Plan unless it causes a financial hardship
12 to the individual.

13 The Governor's proposal would
14 eliminate this financial hardship exemption as I
15 understand it.

16 My question is: how many EPIC
17 enrollees currently fall under this exemption?

18 COMMISSIONER DAINES: I think
19 we -- did we estimate 28,000 would need to
20 enroll? I don't know if that's exactly the same
21 number.

22 MS. DONNA FRESCATORE: That's
23 about right.

24 Currently, about eighty-seven
25 percent of EPIC enrollees are enrolled in Part D.

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2 There's about 26,000 or 28,000 people who meet
3 one of the exemption criteria. Of those about
4 22,000 have enrolled in a Medicare Advantage
5 Plan, so a Medicare Managed Care Plan, without
6 selecting the Part D option.

7 ASSEMBLYMAN DINOWITZ: Do you
8 know what the average cost, in addition to what
9 people already pay, that they would have to bear
10 if this change goes through?

11 MS. DONNA FRESCATORE: It varies
12 by category of Medicaid eligibility.

13 On average, someone who is not
14 in Medicare Part D is about twice as costly to
15 EPIC as a person who is.

16 Once -- EPIC would pay the
17 individual's premium up to the benchmark for the
18 Part D coverage, and then would pay the co-
19 payment as well.

20 ASSEMBLYMAN DINOWITZ: So how
21 much extra would it cost them is my question.

22 MS. DONNA FRESCATORE: It
23 depends on what the drug is. It depends on what
24 category of EPIC they fall into.

25 ASSEMBLYMAN DINOWITZ: Are we

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2 talking tens of dollars, hundreds of dollars,
3 thousands of dollars a year?

4 COMMISSIONER DAINES: Maybe we
5 can do some models and get back to you with
6 typical patients.

7 ASSEMBLYMAN DINOWITZ: Okay. I
8 would appreciate it.

9 Now, the Governor also proposes
10 to eliminate EPIC wraparound coverage for certain
11 drugs not currently covered by an enrollee's
12 Medicare Part D Plan.

13 Under the proposal, if a
14 particular drug is refused coverage by Medicare
15 Part D, the individual would be faced with paying
16 out-of-pocket.

17 Do you know how many people who
18 are currently covered by EPIC -- who are
19 currently covered by EPIC wraparound coverage
20 right now?

21 MS. DONNA FRESCATORE: I don't
22 know that we know the number of people.

23 Under the proposal the senior
24 would need to follow the Medicare Part D rules
25 for coverage for that drug. I think we continue

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2 to pay any -- for the co-payments and for any
3 drugs that fall in the donut hole.

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COMMISSIONER DAINES: And for,
5 at least for barbituates and benzodiazepines that
6 are not covered by Part D.

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So we continue to fill in the
8 real holes that get everyone into Part D.

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ASSEMBLYMAN DINOWITZ: Do you
10 know --

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COMMISSIONER DAINES: It's
12 about a \$33 or \$34 million savings to the State.

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ASSEMBLYMAN DINOWITZ: To the
14 City?

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COMMISSIONER DAINES: To the
16 State.

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ASSEMBLYMAN DINOWITZ: To the
18 State.

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COMMISSIONER DAINES: Is that
20 about right?

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MS. DONNA FRESCATORE: Yes.

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COMMISSIONER DAINES: \$33/\$34
23 million of savings.

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ASSEMBLYMAN DINOWITZ: Which
25 are the most commonly covered drugs that we are

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talking about here that are covered by the wrap?

MS. DONNA FRESCATORE: Well, the numbers that I have --

COMMISSIONER DAINES: We're paying for Nexium, Lipitor, Prevacid, Proscrit, Asmanex, \$.5 million to almost a \$1 million in each of those.

They are just the common drugs. I mean they're not -- EPIC paid \$3.5 million during the recent six months for these five drugs, for those five drugs.

ASSEMBLYMAN DINOWITZ: So, again, do you know how much additional money on the average to people who are impacted by this would have to pay out-of-pocket?

COMMISSIONER DAINES: I don't think we have the figure. We can try to get back to you with something that answers your question.

ASSEMBLYMAN DINOWITZ: Because I would suspect that some people are going -- it's going to be a very significant impact on some of the people who would be impacted by this.

If you could get back to me with that information, I would certainly appreciate

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2 it.

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I actually also had a few questions on a separate matter which was discussed earlier. That's the soda tax.

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You had indicated that, I guess -- I'm inferring from what you said that the main purpose is health as opposed to the \$400 million that it would generate; am I correct?

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COMMISSIONER DAINES: Well, you're talking to the Health Commissioner. So the goal for me is health, and then when that money came back into our budgeting across the Health Department, it really -- we were able to line out a lot of cuts that we didn't have to do. So I got a double hit from it.

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In the long run I think everybody saves because health care costs and premiums go down.

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ASSEMBLYMAN DINOWITZ: Okay.

Now, here's the thing.

I don't happen to personally drink sugared soda. I drink diet soda. I'm not personally convinced that that's the safest thing to do, but I do it anyway although I never let my

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children do it when they were younger.

Not personally being the victim of this soda discrimination, as I say it won't impact me, but you are talking about a tax. I mean essentially it's a sales tax.

COMMISSIONER DAINES: It's an excise tax. It's a producer --

ASSEMBLYMAN DINOWITZ: Well, it's essentially like a sales tax though.

Right now there's a sales tax on soda when you go to the supermarket, eight plus percent.

When I buy a twelve-pack of soda, twelve cans, twelve ounces, a hundred and forty-four ounces, I pay \$2.00 because I only get it when it's on sale.

So this proposal would add, if I'm correct, \$1.44 to that cost, one penny for each ounce; correct?

COMMISSIONER DAINES: That's right.

ASSEMBLYMAN DINOWITZ: Well, 144 over 200 would be -- that's a seventy-two percent tax under those conditions. That seems

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like a lot to me.

I think one of the questioners earlier, one of my colleagues, I think it was Senator Kruger, had mentioned, well, what about candy, what about --

You know, if the issue is health, it seems to me that there are many things that are unhealthy, not only candy. There's cookies, there's cake, there's all the things that most of us love. And Mayor Bloomberg has now decided salt is a very bad thing. And so there's salty snacks, like pretzels and potato chips and a whole host of things.

Soup, when you buy a can of soup, if you ever look at the sodium content, you don't want to look at it, believe me.

Most -- many products have unhealthy levels of sodium in it.

You go to the store and you buy meat, some meats have a high percentage of fat than others.

So my question is, if we want to look at how healthy or unhealthy certain foods are, maybe what we should be looking at are all

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foods. And I'm not saying you should or you shouldn't do this, but maybe you want to impose a small excise tax on a lot of things rather than a large tax on one thing. It might generate more revenue, it might have a greater impact.

But it just seems a little odd to me that one product of many, many products, which are probably not good for you, has been selected. And I'm not sure that's the smartest way to do things.

COMMISSIONER DAINES: Well, we're following the best public health advice, that the increased consumption of sugared sodas is the single, strongest factor that correlates with the rise of obesity. And it's at the extreme of the spectrum of simply sugar and water.

All of the other things you mentioned, all the way back to meat, very complex issue.

And the idea that we don't do everything across all of the nutrition spectrum, therefore we can't do one important thing I just disagree with. I think we can focus on the singlemost important factor driving the obesity

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problem in particular among children and do something there while we work on those other things with calorie labeling and education and making the fresh fruits and vegetables more available. There's lots of things we can do.

But this is one thing we can do that would be effective.

ASSEMBLYMAN DINOWITZ: Well, I would suggest a greater emphasis on what's served at schools would make sense.

So I guess you're saying it's good to get as much as we can and then move on to try to make additional changes.

COMMISSIONER DAINES: Yes. Focus on what's possible today.

ASSEMBLYMAN DINOWITZ: Right.

COMMISSIONER DAINES: You know, there's been a lot of talk about what the price increase is. The effect of this would be that the taxed beverages, the sugared soda beverages, would stand out among other beverages by seventeen percent or one cent an ounce.

Any other calculations that put that higher are miscalculating it. They would

2 simply stand out a penny an ounce higher. If
3 you're paying sixty cents at the deli for a soda,
4 you would pay something in the neighborhood of
5 seventy-two cents. It would stand out in the
6 display case as being more expensive than the
7 alternative item that doesn't have the calories.
8 That's what the effect is.

9 And the beverage industry knows
10 that that will reduce their sales. They have
11 elaborate price elasticity models that when the
12 price of a product goes up ten percent, the sales
13 drop eight or nine percent. They know this.

14 ASSEMBLYMAN DINOWITZ: Okay.

15 Well, I'm not going to belabor
16 the point. But it just seems to me there are so
17 many bad things out there. And I'm no expert on
18 nutrition. But I don't know -- and maybe soda is
19 the worst thing.

20 But it sort of seems to me to
21 cause some kind of distortion when one particular
22 product like that is singled out when we know
23 there are so many bad things out there,
24 particularly for children. And we're really not
25 doing a whole lot to discourage them.

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2 I mean I for one would never
3 dream of eating some of the things that they
4 still serve at school, but they still serve some
5 of those bad things.

6 COMMISSIONER DAINES: Well, the
7 Governor has twice put in a Healthy Schools Act
8 to address that across the State.

9 ASSEMBLYMAN DINOWITZ: Thank
10 you.

11 ASSEMBLYMAN FARRELL: Thank
12 you.

13 Mr. McDonough.

14 ASSEMBLYMAN McDONOUGH: Thank
15 you.

16 And good morning -- well,
17 almost. You have two minutes left of good
18 morning.

19 Good morning and thank you for
20 being here.

21 Most of my questions were about
22 fraud, waste and abuse, and Assemblyman Hayes has
23 covered most of what I had to say.

24 I just want to add one thing
25 about that.

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2 I know that I've had people come
3 to me. And in one case I will tell you I'm
4 concerned about error. We talk about fraud, waste
5 and abuse. And a moment ago, Mr. Sheehan, I think
6 you mentioned error also.

7 To give you an example, I had a
8 person come to me who was a retired physician, a
9 rather young man, but retired because he was
10 disabled, who brought in his EOB, the Explanation
11 of Benefits.

12 And albeit this was a Medicare
13 case, but it was typical. And he showed it to me
14 and he said I just want you to see how much
15 things cost.

16 And he said, for instance, this
17 was for my mother who was in her '80s, he said,
18 and here you can see, look at the price for the
19 amputation of the leg. And it was monstrous.

20 And he said, and look at all
21 these visits.

22 And then he told me, he said, of
23 course she walked out of the hospital on two
24 legs, which was -- you know, obviously I don't
25 know if that would be fraud or a coding error or

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what. And the visits occurred after she left, additional visits being billed.

Now, I think that visit thing probably happens frequently.

And from what I heard from the young lady, I think you do have some mechanisms to look for that; right?

INS. GEN. SHEEHAN: That's correct, Assemblyman McDonough, and I will discuss that in detail in my presentation.

But those -- it's a classic situation where is it an error, is it intentional conduct. You know, either way the government is paying for services that they didn't get.

ASSEMBLYMAN McDONOUGH: Right, right, right.

I think what I'm saying is is there some method that errors are checked at the door so-to-speak. Is there anything -- you take a larger hospital. Is there somebody in that hospital who is reviewing stuff before it gets sent out to you, one of your people maybe, you know?

INS. GEN. SHEEHAN: Well, let me

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2 -- that's a great question.

3 And what the Legislature did in
4 2006, when it created the Medicaid Inspector
5 General statute, was to mandate a compliance
6 program within every hospital and Article 28
7 facility in New York and also certain other
8 providers over \$500,000.

9 So that as of the end of
10 December, all those organizations certify to us
11 that they have an effective compliance program in
12 place as of October 1, 2009.

13 And we're now engaged in a
14 series of efforts which I'll talk about in a few
15 minutes to determine whether, in fact, that's the
16 case.

17 ASSEMBLYMAN McDONOUGH: So some
18 things are looked at before they leave so-to-
19 speak?

20 INS. GEN. SHEEHAN: That's
21 correct.

22 ASSEMBLYMAN McDONOUGH: Before
23 they're forwarded. Okay.

24 And, as I said, Assemblyman
25 Hayes covered most of what I would have wanted to

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say about fraud, waste and abuse.

I had one question, Commissioner Daines.

You talked about this preventable readmissions I think it was called, -

COMMISSIONER DAINES: Yes.

ASSEMBLYMAN McDONOUGH: -- preventable hospital readmissions.

And the numbers you collect there, 70,000 -- estimate 70,000 were potentially preventable.

Now, I get the feeling that hospitals are in the mode of trying to get people out.

Many years ago I worked for Blue Cross and I remember that their idea was get them out, get them out as fast as possible. I don't know if that is still in the hospital mode of thinking even when it comes to Medicaid patients.

But what can you do to tell a hospital maybe you don't want to discharge that patient because they're going to come back, as you suggested in your statement here?

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COMMISSIONER DAINES: Well,
again, hospitals are on a case payment system
which encourages shorter lengths of stay.

ASSEMBLYMAN McDONOUGH: Right.

COMMISSIONER DAINES: But we
don't really see this as an adversarial process
with hospitals. I think the vast majority of
these readmissions are not because the patient
was not ready for discharge. It's because of
preparation and link for post-discharge care.

And I think the hospitals will -
- it will not be so much saying, oh, we'll just
keep them longer, as more attention -- and it's
not just the hospitals, all of our ambulatory
care that we keep emphasizing, and in particular
mental health, because a huge number of these
readmissions are people going from medical care
to mental health care back to medical care and
ping-ponging. And so that's where the work ought
to be.

And I don't at all think this is
a signal to simply keep people in the hospital
longer.

ASSEMBLYMAN McDONOUGH: Okay.

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So they're not -- you made a point there that maybe it would be someone who, I was familiar with, who went from a hospital to rehab and then came back to the hospital.

COMMISSIONER DAINES: Well, or mostly people that fall between the cracks. They didn't get into their doctor appointment soon enough or with the right information about what medicines they ought to be on, and then -- they don't stay on their medicine and they're back in with heart failure.

ASSEMBLYMAN McDONOUGH: Okay.

COMMISSIONER DAINES: Or the psychiatric discharge that wasn't connected to medical care. So then they're back in the hospital with diabetes.

Our lengths of stay in New York have come down. The hospitals have done a lot of work on that. But there's still for most cases typically longer than other states.

And it's not that we need to keep them even longer. It's we need to have those post-hospital care links and a better information system so that people can link up.

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2 ASSEMBLYMAN McDONOUGH: Well,
3 you say that approximately \$813 million in this
4 that could be saved with this preventable
5 potential, and costs \$813. That was in 2007.

6 COMMISSIONER DAINES: Yes.

7 ASSEMBLYMAN McDONOUGH: You say
8 70,000 --

9 COMMISSIONER DAINES: A
10 readmission, who -- you know, again, whether we
11 pay the hospital for it or whether the hospital
12 isn't paid, they are rendering the care and they
13 don't like that either.

14 So no one wins for this, and we
15 can transfer who pays or doesn't pay for the
16 unnecessary admission. But these days you don't
17 get a patient in and out of the hospital for
18 \$10,000 or \$12,000 or more, in particular, these
19 complex elderly and mixed psychiatric and medical
20 patients.

21 And I know that no one in a
22 hospital likes to see that patient come back when
23 they're not supposed to.

24 ASSEMBLYMAN McDONOUGH: Okay.

25 All right. And to switch gears,

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2 and just to say one thing about this soda tax.

3 Is some of that money you're
4 talking about that could be, by a tax, I would
5 assume is going to be used to really enhance the
6 education process of the dangers of this; right?

7 COMMISSIONER DAINES: We
8 applied that really across our whole health care
9 budget to reduce cuts and to keep a little more
10 funding in programs. And our obesity coalitions
11 and other programs got some money, but not the
12 lion's share of the \$450 million.

13 We see obesity as a burden on
14 the whole system and, frankly, needed the money
15 to reduce the amount of cuts across the whole
16 system.

17 ASSEMBLYMAN McDONOUGH: Thank
18 you very much.

19 Thank you, Chairman.

20 ASSEMBLYMAN FARRELL: Thank you
21 very much.

22 No other questions?

23 (No response.)

24 ASSEMBLYMAN FARRELL: Thank you
25 very much.

1

2

COMMISSIONER DAINES: Thank

3

you.

4

(There was a brief recess in the

5

proceedings.)

6

ASSEMBLYMAN FARRELL: Good

7

afternoon.

8

Office of Medicaid Inspector

9

General, James Sheehan, Inspector General.

10

And we have been joined by

11

Assemblyman Morelle.

12

INS. GEN. SHEEHAN: Chairman

13

Farrell, you're ready for me to go?

14

ASSEMBLYMAN FARRELL: Yes.

15

INS. GEN. SHEEHAN: Committee

16

Chairs Farrell and Gottfried and Committee

17

Members:

18

I want to thank you for the

19

opportunity to present Governor Paterson's budget

20

and goals for the Office of Medicaid Inspector

21

General this year.

22

Governor Paterson said in the

23

State of the State this is a winter of reckoning

24

for the government and people of New York.

25

This message is especially

1
2 important when we look at our State's Medicaid
3 program.

4 New York's Medicaid program, as
5 Commissioner Daines pointed out, is the largest
6 in the country and over \$50 billion for the next
7 fiscal year. And the citizens of our State need
8 to trust that we, as a State, are doing
9 everything possible to assure the Medicaid
10 dollars are well spent and that providers who
11 receive those dollars are appropriately
12 accountable.

13 The Governor has called upon
14 OMIG to continue and increase our efforts to
15 ensure the integrity of the Medicaid program, and
16 the Governor's budget provides resources
17 necessary to achieve that goal.

18 The Executive Budget proposes a
19 series of actions to improve the coordination,
20 administration and public benefits, some of which
21 are covered by OMIG and some of which are in
22 other agencies.

23 These include:

24 Increased civil penalties for
25 civil fraud;

1
2 Shared services between OMIG and
3 the Office of Welfare Inspector General;

4 Increasing ability to match
5 individuals and providers who are excluded from
6 the Medicaid program so that we can identify them
7 where they are working in other organizations;

8 Work with assuring that there is
9 an asset verification program that will identify
10 assets held by estates;

11 And working with the Department
12 of Labor to make sure that employers who have
13 people on as contractors who are under the table
14 are held appropriately accountable.

15 Assuring the good stewardship of
16 over \$50 billion in Medicaid expenditures, the
17 mission of the OMIG, which is our background, the
18 agency's authority directs preserving the
19 integrity of the State Medicaid program by
20 detecting and preventing fraudulent abuse and
21 wasteful practices within the Medicaid program
22 and recovering improperly expended Medicaid
23 funds.

24 As we'll talk about later, the
25 State's efforts to prevent and detect waste,