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2 fraud and abuse have taken us from a national  
3 symbol of Medicaid fraud, waste and abuse in 2005  
4 to the nation's leader in recovery dollars and  
5 program integrity today.

6 While much more remains to be  
7 done, the State's progress to date reflects three  
8 things:

9 First, legislative and executive  
10 leadership in creating an effective fraud control  
11 program;

12 Second, improvements undertaken  
13 by the provider community; and

14 Third, good work on the part of  
15 all the entities responsible for program  
16 oversight and enforcement.

17 There are a lot of agencies  
18 involved in that effort, including the Department  
19 of Health, the Attorney General's Medicaid Fraud  
20 Control Unit, the other State agencies, including  
21 the oversight agencies, the county social  
22 services agencies, the Office of State  
23 Comptroller, and various government contractors.

24 OMIG, in addition, works with  
25 the FBI and Task Forces in New York City, Albany,

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2 Rochester and Buffalo, and a Strike Force in  
3 Brooklyn, and a DEA Task Drug Enforcement  
4 Administration Task Force in Albany.

5 And we work on the county level  
6 too with local district attorneys and local  
7 social services agencies.

8 The improvements that we've seen  
9 in the last three years stand in dark contrast to  
10 where we were five years ago.

11 In July of 2005, a series of  
12 articles in The New York Times painted a painful  
13 picture of New York State's Medicaid program:  
14 quote, Medicaid has morphed into an economic  
15 engine that fuels one of the State's biggest  
16 industries, leaving fraud and unnecessary  
17 spending to grow in its wake, unquote.

18 Quote, the lax regulation of the  
19 program did not come about by chance. Doctors,  
20 hospitals, health care unions and drug companies  
21 have long resisted attempts to increase the  
22 policing of Medicaid.

23 These articles and later reviews  
24 by the Federal Center for Medicaid and Medicare  
25 Services, the HHS Office of Inspector General and

1  
2 the State Senate Finance Committee addressed the  
3 reduction of staff, State staff, responsible for  
4 audit and investigations, and the approach of  
5 audit reviews as provider education rather than  
6 recovery of improper payments.

7           Within a year after that New  
8 York Times series, the Legislature created the  
9 independent office of Medicaid Inspector General.

10           As the State's first Senate  
11 confirmed Inspector General, I came to the new  
12 agency task with overseeing the largest Medicaid  
13 program and recovery commitment of the Federal,  
14 State Health Reform -- Federal, State Health  
15 Reform Partnership, which required that New York  
16 alone exceed the total 2006 national Medicaid  
17 fraud and abuse recovery for the entire country.

18           New York has met its FSHRPs, so-  
19 called FSHRP obligations of the Federal  
20 government. We have improved the controls in the  
21 Medicaid system to keep bad providers out.

22           We have met very aggressive  
23 budget targets for recoveries and avoided costs  
24 set by the Governor and Legislature. And attached  
25 to my testimony is a chart which shows that in

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2 2006 the avoided costs and recoveries totalled  
3 \$300 million. The budget for 2010 and '11 has a  
4 goal of \$1.2 billion, which we have committed to  
5 meet.

6 As part of our budget message, I  
7 want to give you a progress report on where the  
8 Office of Medicaid Inspector General is today and  
9 where are we going. And I hope I'll leave you  
10 with an understanding of how the Governor's  
11 commitment and the Legislature's commitment has  
12 resulted in lower costs and greater  
13 accountability.

14 The 2010-'11 Executive Budget  
15 provides for \$88 million, including \$50 million  
16 of Federal funds. We are projecting that OMIG  
17 will have a workforce of 659 by the end of this  
18 year and anticipate filling another 70 positions  
19 next year in the next fiscal year.

20 We've used a four-step approach  
21 to meeting our statutory and budget obligations.

22 First, we've conducted an  
23 examination of every major component of Medicaid  
24 expenditures to determine the amount paid in that  
25 area, the audit and investigative activity

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2 committed to it, and the risks of fraud and  
3 abuse.

4 This includes the use of  
5 significant new data mining techniques and  
6 technologies. As a result of this effort, OMIG  
7 has expanded its efforts to look more closely at  
8 the fast-growing areas of managed care, home  
9 health care and personal care.

10 Second, we've conducted,  
11 together with CMS, an examination of the Medicaid  
12 program through a random sample to determine the  
13 extent of improper payments of claims based upon  
14 the patient records submitted by providers.

15 For the Federal fiscal year  
16 2008, our review showed that the improper payment  
17 of claims was less than 1.5 percent of Medicaid  
18 expenditures.

19 There's no question that this is  
20 a significant amount of money, but it is  
21 substantially better than the performance of  
22 Medicaid and Medicare programs in most other  
23 states and reflects we think our audit efforts,  
24 the improvements by DOH in its payment and edit  
25 systems, and providers' compliance efforts.

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2 Third, State law now requires  
3 that every provider billing over \$500,000 have an  
4 effective compliance program, including auditing  
5 of its billings and disclosure of overpayments.

6 In 2009 alone, we received over  
7 eighty-five disclosures from New York health care  
8 providers of improper billing and payment. And  
9 that's disclosures. That is, they came forward  
10 and told us that they had billed improperly.

11 The overpayment disclosures  
12 reflect, we think, a significant provider  
13 commitment to the compliance process and have  
14 educated our agency about potential weaknesses in  
15 billing and claims to look at in other providers.

16 Where a provider has an  
17 effective compliance program, including reliable  
18 auditing of areas that OMIG would otherwise  
19 audit, we want to refocus our audit activity to  
20 providers who have not demonstrated an effective  
21 compliance program and reduce the burdens on  
22 compliant providers.

23 Fourth, OMIG has begun a series  
24 of initiatives designed to address significant  
25 gaps between the requirements of law, proper

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2 medical and billing practices and the practices  
3 of some providers.

4           These initiatives involve data  
5 analysis and focusing on encouraging entities to  
6 change their ways, identifying system weaknesses  
7 and identifying providers who are what we call  
8 frequent flyers, that is, providers who keep  
9 showing up on our data mining audit efforts for  
10 more intense audit and investigative attention.

11           And I wanted to walk through one  
12 example of this, the Step Four, which is our  
13 deceased patients project, which we began that in  
14 August of 2009 with an open letter to providers  
15 that said we would be targeting claims for  
16 patients who were deceased at the time that the  
17 services were allegedly performed. So these are  
18 patients who are dead and the providers billed us  
19 for those patients.

20           We selected the month of October  
21 2009 to begin our identification.

22           And we identified 290 claims for  
23 services to patients who were, according to our  
24 records, deceased.

25           On December 1st, we sent letters

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2 to each provider asking for information within  
3 fifteen days about the person who provided the  
4 service, the person that billed the service, the  
5 documents that support those services and  
6 billing, and we asked for evidence if they  
7 believed the patient was still alive because we  
8 occasionally make mistakes and we want to make  
9 sure we get it right.

10 We've learned a great deal from  
11 that project.

12 A number of provided responded  
13 identifying errors that they had made - for  
14 example, wrong service date, billing for a dead  
15 twin instead of a live one, billing from a roster  
16 of scheduled patients instead of on performance  
17 of the service.

18 These are -- the next thing.  
19 Over 150 providers claimed that the patient was  
20 still alive at the time of service. We think  
21 that's pretty unlikely based upon our experience  
22 with the death data in New York, and we are going  
23 to follow it up in March with death certificates  
24 and then come back to it.

25 Two months after the letters

1  
2 went out, given that we asked for information in  
3 two weeks, fourteen providers have not responded  
4 at all, despite the fact that the letter was  
5 Certified Mail and they receive follow-up calls  
6 and in some cases by me personally to say where  
7 is your information.

8 Some responses from the  
9 providers were very instructive.

10 In one pharmacy the patient's  
11 prescription was picked up two days after her  
12 death by another family member.

13 In another the patient's  
14 physician requested delivery of the patient's  
15 prescription to his office after she died.

16 One dead patient's Medicaid  
17 number visited three dentists in the week after  
18 the patient's death.

19 A family accepted delivery on a  
20 new bed paid for by Medicaid after the patient's  
21 passing.

22 One provider explained that the  
23 person responsible for the improper  
24 transportation billing had, quote, returned to  
25 Miami, unquote.

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2 A major teaching hospital  
3 received the body of a deceased Medicaid patient  
4 to harvest organs for transplant but billed  
5 Medicaid as though they were treating a live  
6 patient.

7 The Medicaid program is - and  
8 we're going to follow up that project each month  
9 to find out who continues with the billing  
10 activity.

11 The Medicaid program is one of  
12 the most reliable payers of claims submitted to  
13 it despite the fact the law says it should be the  
14 payer of last resort.

15 So we spend time specializing  
16 some of our work to make sure that the private  
17 insurers, the Federal government or the  
18 appropriate insurer is liable for those payments  
19 and is the one that pays first. That's because we  
20 believe, that the Governor and you do, that  
21 taxpayers should not foot the bill when someone  
22 else is really responsible.

23 With this work, in addition to  
24 other things, we'll be able to meet the audit  
25 plan goals. And New York again leads the country

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in this work.

The next piece that's important to us is openness and transparency. We have assembled a seventy-page work plan to be published every year, which is unique among the states. It's available on our website.

We have more than sixty public speaking events each year.

And we also are working hard to assure that our audit process is transparent.

The five steps that are involved in the audit are explained to providers in a consistent, reliable way. And we have been working hard to make sure that happens.

We've also begun a survey of auditees to measure our auditors' performance.

And we will need your help again. Our audit target for 2010 and 2011 has increased by \$300 million to an overall State fiscal year target of approximately \$1.2 billion.

We've been asked by many people if that target is achievable. Based on past experience, we believe that it is. We need the resources that the Governor requests in the

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2 budget this year more than ever before.

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4 We also have our FSHRP  
5 obligations. The year of FSHRP, which ends  
6 October 1st, we will meet that target. The FSHRP  
7 target for fiscal year 2011 is \$644 million,  
8 which is more than any state has ever recovered  
9 for one year in the history of the Medicaid  
10 program. So that's going to be a very tough  
11 target.

12

13 Along these lines I recently  
14 testified at a Senate hearing that Senator  
15 Johnson held where I and my staff listened to  
16 concerns raised by provider groups about OMIG  
17 audits and their effects on provider operations.

18

19 We are committed to continuous  
20 improvements. We listened carefully to the  
21 testimony and read the testimony that was  
22 presented at that hearing.

23

24 We've put some controls in place  
25 since then, including we now are -- we have been  
26 and we are now making it formal, cancelling  
27 audits where the initial probe finds there's a  
28 very low-level of non-compliance.

29

30 We also work very closely with

1  
2 our other agencies to make sure we know what the  
3 rules are and that the rules are consistent.

4 And in the last few weeks we  
5 have made a major effort to determine the nature  
6 and extent of the concerns of providers and make  
7 sure that responses to them are incorporated in  
8 what we are doing.

9 I think the result of this has  
10 been renewed commitment to the core values of the  
11 agency and an improved focus on our mission.

12 We need your support to make  
13 this effort work. I recognize that there are  
14 differences of opinion about the nature and  
15 extent of auditing activity.

16 I do think that if we look at  
17 New York, and I've been to a number of other  
18 states to find out practices they engage in, that  
19 New York has more due process for providers and  
20 also has the larger recoveries than any other  
21 state in the country. And I think that those two  
22 things go hand-in-hand.

23 I thank you for your continued  
24 support and for the opportunity to speak here  
25 today.

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ASSEMBLYMAN FARRELL: Thank  
you.

The rushed-in Senator.

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

Good afternoon, Mr. Sheehan.

Mr. Sheehan, again, you  
indicated for the record that you did testify at  
a hearing that was convened by the Senate  
Investigations and Government Operations  
Committee on January 7, 2010 with respect to your  
office's work on recovering Medicaid fraud.

Let me see if I understand. And  
I just have a few questions.

According to your testimony  
today, the audit target, the budget target, for  
your department is \$300 million; is that correct?

INS. GEN. SHEEHAN: No. The  
budget target is \$1.2 billion.

SENATOR JOHNSON: I'm sorry.

Well, I was reading -- okay.

So your audit target this year  
is \$1.2 billion.

INS. GEN. SHEEHAN: No, no.

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2                   Let me -- the budget target,  
3 which is recoveries and avoided costs, is \$1.2  
4 billion in State funds. And that includes a range  
5 of techniques that we use to address these  
6 issues.

7                   So it includes audits. It  
8 includes the money that is recovered through the  
9 third party, you know, looking to make third  
10 parties pay first. It includes avoided costs from  
11 a number of programs we conduct, including  
12 prepayment review.

13                   There's a whole range of -- I'd  
14 say that in our product line there's a whole  
15 range of products that get us to that \$1.2  
16 billion.

17                   SENATOR JOHNSON:   And you've  
18 indicated that you believe the number is  
19 achievable in your testimony; correct?

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

22                   SENATOR JOHNSON:   And you're  
23 also, though, on top of the \$1.2 billion, you are  
24 obligated under the FSHRP agreement to recover  
25 another \$644 million.

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INS. GEN. SHEEHAN: Let me --  
it took me the first year I was here to  
understand the difference between the budget  
goals and the FSHRP goals. Let me see if I can  
give you the thirty-second version.

The FSHRP goal is what New York  
State as a whole achieves. So that some of those  
recoveries are by OMIG, some of those recoveries  
are by the Department of Health directly, some of  
those recoveries are by the Attorney General. The  
number in some of those recoveries can come from  
other sources, including voluntary disclosures.

The total, which is the number  
that I've talked about, includes all those.

Whereas the State budget number  
is just State funds, the FSHRP number is State  
and Federal funds.

SENATOR JOHNSON: Okay.

So you're not obligated yourself  
or OMIG to recover the \$644 million. That's going  
to be a group effort to hit the goal of \$644  
million; is that correct?

INS. GEN. SHEEHAN: It's a  
State effort. We're responsible for accounting

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for it. And my guess is if it's not met, that we will be asked why because we're the party with responsibility for measuring.

SENATOR JOHNSON: Aren't you concerned, though, about that this puts into -- calls into question the integrity of an audit process, that you have a predetermined amount of at least \$1.2 billion, that you yourself have now testified that you think that the number is doable, that that is now setting the bar, and you have now said we have to hit \$1.2 billion with a range, you know, third party payers, audits, whatever it may be.

At this point, though, aren't you now telling the health care provider community that you're going to hit this number and it's going to be by any means possible?

INS. GEN. SHEEHAN: Okay.

Senator Johnson, I think every good business sets goals and targets for what they expect to achieve and that we do that too.

I will tell you that we have articulated to our staff that the manager's job is to identify the activities which we think are

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necessary and which are likely to be productive.  
But their job is to do the audit according to  
professional standards.

And I believe and expect that  
our employees do it that way.

The -- as I said, the targets we  
think are within the range of what's achievable  
and they are consistent with the work we've done  
up until now.

And you have my personal  
commitment that we're going to do a good job the  
right way. If we don't meet the goal, then I'll  
be responsible for management practices. But I'm  
not going to be a person who says we are going to  
do something that's unethical, illegal or  
improper.

SENATOR JOHNSON: At the  
hearing, at your testimony, you discussed the  
three terms - waste, fraud and abuse.

My understanding from the  
definitions of the Centers for Medicare and  
Medicaid Services, which OMIG has acknowledged to  
be -- is the first in the established hierarchy  
in the world of Medicaid policy, I have found the

1  
2 definitions of abuse and fraud and the concept of  
3 fraud and abuse.

4                   However, I couldn't find  
5 anywhere in their reports the terms "waste" or  
6 "improper payment," no definition whatsoever.

7                   On your own website your bullet  
8 points describe what is fraud. But, again, you  
9 have no bullet points as to what is waste.

10                   So what I want to get an  
11 understanding is - and, more importantly, sorry,  
12 you know in your testimony you described an  
13 improper payment as any payment that should not  
14 have been made or was made in an incorrect  
15 amount.

16                   So maybe you could provide me --  
17 because this is a standard you used to go out to  
18 the providers.

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

21                   SENATOR JOHNSON:     How do you  
22 come up and determine what an improper payment  
23 means?

24                   INS. GEN. SHEEHAN:     CMS has  
25 actually addressed this issue. And the United

1  
2 States Congress has addressed this issue in  
3 something called the Improper Payments Act of I  
4 believe 2002.

5 And what it does is it requires  
6 every Federal agency to account for improper  
7 payments and to make, and in an accounting sense  
8 that they make a reasonable estimate of what the  
9 improper payments are, and to set goals for  
10 reducing the improper payments.

11 So the concept of improper  
12 payments is very clearly defined in the statute.

13 In addition, the Government  
14 Accountability Office has done a number of  
15 reviews of improper payments.

16 And I testified in Washington  
17 about the improper payment issues within Medicaid  
18 I think last April.

19 So improper payments is standard  
20 Federal nomenclature and well-recognized.

21 The second piece, I think you  
22 asked about waste. And the issue in waste is are  
23 we getting for the dollars that New York State  
24 taxpayers spend the appropriate measure of  
25 services both in quality and in quantity.

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2 And that I believe was added to  
3 our statute or OMIG's statute by the Legislature.

4 SENATOR JOHNSON: But what's  
5 the guide that you use with respect to waste? I'm  
6 a little -- I'm still confused.

7 If CMS doesn't have a definition  
8 of waste, what do you use as your guide for  
9 waste?

10 INS. GEN. SHEEHAN: Any payment  
11 that is received for service that was either not  
12 performed or -- you know, I'm going to -- I'm  
13 giving you examples rather than a complete  
14 definition.

15 Let me get back to you on that.  
16 I believe we defined waste in at least one of our  
17 presentations to the provider community.

18 SENATOR JOHNSON: Okay.

19 At the January 7th hearing, you  
20 also said that improper payments are caused by  
21 accidents, failure to have good systems or the  
22 result of people with evil in their hearts.

23 And then you also testified that  
24 you have to - and I mean by "you" your department  
25 - have to see which is which.

2 Do you differentiate between  
3 different reasons for these improper payments  
4 when you determine the fine or penalty that is  
5 going to be levied against the providers?

6 If somebody, let's say, has an  
7 improper payment based on accident, do you, you  
8 know, give them maybe less of a penalty than  
9 somebody else who has an improper payment based  
10 on evil in their heart?

11 INS. GEN. SHEEHAN: Yes.

12 SENATOR JOHNSON: And how do  
13 you come up with that?

14 INS. GEN. SHEEHAN: How --

15 SENATOR JOHNSON: How do your  
16 auditors come up with that?

17 INS. GEN. SHEEHAN: Remember,  
18 we're talking in apples and oranges here, I  
19 think.

20 There are a series of functions  
21 within our agency. So in investigations our  
22 responsibility is to identify -- first, to  
23 identify providers who failed to comply with  
24 their responsibilities, and then to assess their  
25 state of mind or motivation to determine whether

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2 it's a fraud case.

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4 And if it's a fraud case, we are  
5 required by statute to refer to the Attorney  
6 General.

6

7 And if we -- within our own  
8 house we have the ability to impose civil  
9 penalties, to exclude the provider from the  
10 Medicaid program, or to take other remedial  
11 action to address the conduct they engaged in.

11

12 So the assessment of motivation  
13 is done primarily in the investigative side, and  
14 to some degree in what we call the business  
15 automation side, you know, why did this happen.

15

16 The audit side's focus -- the  
17 audit side does not impose penalties. Penalties  
18 are imposed only by the investigation side.

18

19 The audit side looks to improper  
20 payments that either should not have been made or  
21 should not have been made in the amount that was  
22 claimed.

22

23 And for that we calculate an  
24 overpayment based upon several recognized audit  
25 techniques and we collect that overpayment.

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SENATOR JOHNSON: Okay.

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And some of those techniques include, let's say, extrapolation; correct?

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INS. GEN. SHEEHAN: I'm sorry?

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SENATOR JOHNSON: Some of those techniques include extrapolation; correct?

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INS. GEN. SHEEHAN: That's correct, Senator.

9

SENATOR JOHNSON: Okay.

10

You talk about in your testimony -- I'm looking at your written testimony -- for instance, that you pride yourself as an agency -- I'm sorry -- OMIG is an agency that prides itself on openness and transparency.

15

You indicate that you train your staff to make sure that you walk every provider through what the audit process is going to look like as much as possible.

19

And you talk about how, I guess, you have regular meetings with provider groups and members about the audit concerns. And that's correct?

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INS. GEN. SHEEHAN: That's

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correct.

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SENATOR JOHNSON: How do you go

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about doing this? You know, how do those meetings go with the provider groups?

INS. GEN. SHEEHAN: The meeting with the provider groups?

SENATOR JOHNSON: How do those meetings go? Are they well attended? What's the atmosphere in those meetings?

INS. GEN. SHEEHAN: That's a good question.

I think -- I've been doing this now for three years. I try to show up before my presentation to see if there are other things being -- because you want to listen as well as speak.

And my perception -- you know, this is my perception -- is they've gone extremely well and that we lay out the detail what we are trying to do and how we are doing it.

I think the response has been positive.

Now, it's -- give you an example. There's the Greater New York Hospital Association. I was asked to speak for an hour-and-a-half. They kept me for over two-and-a-half

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2 hours. And, you know, it wasn't because they  
3 loved me, probably not. But it was -- I thought  
4 it was a very useful and fruitful back and forth  
5 discussion.

6 I have also been at sessions  
7 where people have discussed their concerns about  
8 some of our audits and I took that information  
9 back to my agency and asked are we doing it  
10 properly and tell me what safeguards we have in  
11 place.

12 And as a result of those  
13 conversations, we have I think improved our audit  
14 process.

15 And as I said in my testimony,  
16 we also are trying to, in developing our  
17 questionnaire, to identify the level of  
18 satisfaction auditees have with our process. We  
19 incorporate the information we gain from  
20 listening to people at these sessions.

21 SENATOR JOHNSON: With respect,  
22 though, to walking every provider through what  
23 the audit process is going to look like as much  
24 as possible, I've been provided, in connection  
25 with the hearing, Mr. Sheehan, with

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2 correspondence involving a provider in the  
3 cerebral palsy universe so-to-speak. And I have  
4 read correspondence after correspondence after  
5 correspondence from their counsel to your  
6 auditor, to your audit manager, begging to get an  
7 understanding of an audit process, getting an  
8 understanding of a methodology, trying to even  
9 ask what claims are you grabbing a sample from.

10

And it seems that every  
11 correspondence is met with silence or we'll get  
12 back to you or we'll do something. I have a two-  
13 year correspondence. And your office I'm sure is  
14 well aware of the incident that this is  
15 involving.

16

I have a hard time -- I really  
17 do have a hard time believing that there is some  
18 sense of openness with the provider community. Do  
19 you know why? Because they have been coming to me  
20 before I had the hearing, since I've had the  
21 hearing and to let you know that I'm going to  
22 reconvene the hearing on March 17th or I'm going  
23 to ask Mr. Foley to come and testify at the  
24 hearing about the audit process because it's non-  
25 stop. It's not a trickle, it's a deluge of people

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2 greatly concerned about the lack of openness, the  
3 lack of transparency, the lack of understanding  
4 what the audit process looks like.

5 I mean the insensitivity of an  
6 audit process starting and holding on for months  
7 from your office and then demands that they  
8 immediately comply with certain document requests  
9 within thirty or sixty days.

10 There seems to be a little bit  
11 of a disbalance --

12 INS. GEN. SHEEHAN: Senator  
13 Johnson, --

14 SENATOR JOHNSON: -- involving  
15 the providers.

16 INS. GEN. SHEEHAN: -- I'm  
17 happy to look into -- last year we did about  
18 1,200 audits. And I'd be happy to look into the  
19 specifics of the case you're talking about.

20 SENATOR JOHNSON: When do you  
21 post the audits online?

22 INS. GEN. SHEEHAN: When the  
23 audit is final.

24 SENATOR JOHNSON: When it's  
25 final, not draft?

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INS. GEN. SHEEHAN: No.

SENATOR JOHNSON: We've never posted an audit online that's been in draft form and have had to take that audit down?

INS. GEN. SHEEHAN: I would not -- I don't know the answer to that. Our policy certainly is to post it as final.

SENATOR JOHNSON: The answer is that you actually have and you've had to remove it.

And my concern is that by posting an audit online and then removing it, to change it, you still besmirch the reputation of those particular providers.

I'll ask one final question.

The Metropolitan Jewish decision, we've had a lengthy discussion about that. And correct me -- Metropolitan Jewish won at the ALJ, the Administrative Law Judge, level; is that correct?

INS. GEN. SHEEHAN: That's correct, Senator Johnson.

SENATOR JOHNSON: Have you paid them back yet?

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INS. GEN. SHEEHAN: We have not paid them back.

As a result of -- that decision came down, I believe, in December. We've since had a decision by a different Administrative Law Judge going in the other direction on this issue, and we are reviewing internally what approach we want to take with respect to the bed hold reserves generally.

SENATOR JOHNSON: Wait a minute.

Here's the interesting thing. Have you filed an appeal?

INS. GEN. SHEEHAN: We have not.

SENATOR JOHNSON: Okay.

Because my understanding, and let me quote you from the hearing on January 7th, quote, this is you: Then there is a final audit. If they're unhappy with the results of the final audit, they have a right to appeal to an Administrative Law Judge. If we don't like that, if we don't like the Administrative Law Judge opinion (sic), tough luck. If they don't like the

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2 Administrative Law Judge opinion, they get to  
3 appeal to the Supreme Court of New York. And if  
4 they're successful on that appeal, then the  
5 decision of the OMIG can be reversed or altered.

6

By your own, your very own  
7 testimony, you lost at the ALJ level. You owe  
8 them, Metropolitan Jewish, at least \$900,000,  
9 when you add in interest, about \$1.5 million.

10

By your very own testimony, you  
11 said you're out of luck.

12

Now you're telling me today,  
13 because of a different ALJ in a different case,  
14 not involving Metropolitan Jewish, you're just  
15 taking the opinion I don't have to pay them.

16

INS. GEN. SHEEHAN: Senator  
17 Johnson, --

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SENATOR JOHNSON: That's not  
19 how collateral estoppel works, that's not how res  
20 adjudicata works. You lost. Are you going to pay  
21 them or not?

22

INS. GEN. SHEEHAN: We have an  
23 obligation to pay Metropolitan Jewish back,  
24 you're correct.

25

SENATOR JOHNSON: Under the

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2 I want to go back to a very  
3 simple straightforward process question. And I  
4 asked Commissioner Daines, and I deferred a  
5 little bit because I thought it would be  
6 appropriate maybe for you to also make a comment.

7 My general premise is that,  
8 while the collection activity of the Medicaid  
9 fraud, waste and abuse that we know is out there,  
10 we haven't been able to quantify it. You haven't  
11 been able to quantify it beyond the budget  
12 target, but you do go after it after it's already  
13 out of the door.

14 My question specifically: are  
15 you engaged in any initiatives to work with the  
16 Health Department on the front end before those  
17 claims are paid to make sure that only proper  
18 payments are made on those claims?

19 INS. GEN. SHEEHAN: We do three  
20 things along those lines, Assemblyman Hayes.

21 The first one is we meet with  
22 them on a regular basis to go over edits. And  
23 these are computerized rules that are built into  
24 the system to determine whether payment is  
25 appropriate.

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2                   So, for example, a hysterectomy  
3 on a male is one kind of edit that you've built  
4 in.

5                   We found in New York State  
6 several years ago that there were a significant  
7 number of people identified as male who were --  
8 we were getting billed for pregnancy. So you  
9 build in an edit change to make sure that when  
10 those two events occur, that the claim is  
11 rejected by the system.

12                   So that edit process is an  
13 ongoing process. And, of course, you know, you  
14 identify new issues all the time on our audits  
15 and you feed it back.

16                   The second thing is that I meet  
17 with the head of the Office of Health Insurance  
18 Programs on a biweekly basis to identify what  
19 we're finding in our audits and what we think  
20 would be appropriate, and the discussion of how  
21 we could fix it going forward.

22                   And part of that is a discussion  
23 about reimbursement reform. Part of that is a  
24 discussion about just what's happening on a day-  
25 to-day within the agency.

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2           The third thing that we do with  
3 respect to this effort of identifying fraud  
4 before it goes out the door is to look at the  
5 controls that are put in place for provider  
6 enrollments.

7           And one of the difficulties that  
8 we faced in New York is that we have two separate  
9 lists of excluded providers: one for the State,  
10 which is 6,000 people or entities, and one for  
11 the Feds, which I think is around 40,000.

12           And so we are trying to get the  
13 message out with the Department of Health that  
14 excluded providers cannot be -- not only can they  
15 not be enrolled, but they can't provide services,  
16 and that with built-in controls it will make sure  
17 that those people do not work in the industry and  
18 provide services to our patients.

19           So it's not a perfect system.  
20 But I think we have made significant progress on  
21 each of those fronts.

22           ASSEMBLYMAN HAYES:    You gave  
23 some specific examples of how you assist.

24           I guess maybe what I'm trying to  
25 get at is a basic understanding of the process

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from the beginning when a claim comes in the door until the end when a claim goes out the door, so prior to you going after it in an audit or having a specific referral.

When the Comptroller of the State of New York has an audit and says that there are 26,000 dual numbers out there, it boggles the mind to believe that there is a need of an edit in a computer system that wouldn't be as elementary as catching people that have dual numbers.

So can you just quickly walk me through from the minute that a claim comes in. Is there one central place where it gets processed? Does it automatically get processed through a computer? Are there certain codes that are processed? Help me understand that step.

INS. GEN. SHEEHAN: There are two separate issues in your question.

The first is the eligibility of the patient - all right? - which the -- there's a claim system and a patient system.

If the patient system says the patient is eligible, the claim is going to get

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2 paid because that's the communication between the  
3 two systems.

4 So I'm going to focus right now  
5 on the claim system.

6 When a claim is submitted -- and  
7 I preface this by saying I don't pretend to be an  
8 expert in how all of these claims work, but I've  
9 seen enough from cases to be able to talk I think  
10 reasonably intelligently about them.

11 Every claim that comes in -- we  
12 basically have an honor system on claims. If a  
13 provider says I did this service - all right? -  
14 or this service was ordered by a physician and  
15 here's the name of the physician, we assume --  
16 the claim system assumes that the statement in  
17 that claim is accurate. All right? Because you've  
18 got probably a billion claims a year and the  
19 system would stop if you investigated every one  
20 before payment.

21 The claim then goes through a  
22 series -- so the question is, what - you know,  
23 what was the service performed and was it  
24 performed by this provider. So it now goes  
25 through a series of edits. And the edits are

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designed to determine whether, you know, is it an enrolled provider, for example, is this service one that is consistent with the diagnosis. So you're not going to do an appendectomy on someone who has a headache. So it goes through edits that are related to procedure codes and edits that are related to diagnosis codes.

          If you had a prior appendectomy, you're not going to get a second one.

          If you've had a toenail removal on one foot, you're not going to have a second one.

          If you've had a tooth removed, for the most part you're not going to get the same tooth removed again.

          That claim -- so it goes through the edit process and then essentially it's approved for payment, which means that there are no objections.

          And then several weeks later the claim gets paid.

ASSEMBLYMAN HAYES:     And is --

INS. GEN. SHEEHAN:     If I could, there's really -- it's an automated process and

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2 the only exceptions to that automation process  
3 are when either Health or OMIG says -- well,  
4 except for -- this is -- there are prior  
5 approvals for some kinds of services or prior  
6 authorizations for some kind of services. So you  
7 have to have that in before it gets paid.

8 There are certain kinds of  
9 services that we make a determination or Health  
10 makes a determination we want to see the claims  
11 and underlying medical records before the service  
12 is paid.

13 So, for example, we've done a  
14 number of dental reviews. We say if the claim has  
15 these three thresholds, then we want to see the  
16 documentation that the dentist has.

17 But for the most part it's a  
18 trust system that relies upon the providers  
19 telling us the truth and accurate facts about  
20 what they did.

21 ASSEMBLYMAN HAYES: And then,  
22 since it's totally automated, the only time that  
23 it would actually be brought before a review of a  
24 real live human being would be if it met any of  
25 those criteria? And then how many criteria are

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2 there?

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INS. GEN. SHEEHAN: Well,

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that's --

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ASSEMBLYMAN HAYES: I imagine

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it has to be a triage system in processing that

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many claims.

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But I'm trying to understand if

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it's completely automated or if, in fact, there

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is something that happens as part of that

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automated process that would then trigger it to a

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higher level of scrutiny and evaluation by an

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individual.

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INS. GEN. SHEEHAN: Let me --

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here's what's happening. When I first started in

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health care, if you wanted to see claims

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processed, you go down to the basement of Blue

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Cross and there would be like thirty people in

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cubicles going through with their, you know, the

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rubber thing at the end of their thumbs looking

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at the claims. They were all on paper and often

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with supporting documentation.

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Every system in the country has

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now moved towards automated claims.

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And what we have to do is

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replace -- we have to replace the intelligence of the person sitting at the desk in the basement of Blue Shield with the intelligence of the system.

So we use a series of what I would call slices to figure out what's really going on with a claim.

So, for example, some providers are going to be looked at because they had a rapid surge. So last week they had no -- last month they had no claims, this month they have \$100,000. It doesn't mean they're bad people. It means you should take a closer look at their claims.

Some of the issues will relate to networks of providers. You know, it says this doctor wrote \$6 million worth of orders for this one particular facility.

So what you try to do is take a series of slices to say, replacing those people in the basement at Blue Cross with what do we know, what have we learned from the work of our auditors and our investigators who want to feedback into the system.

And some are prepayment and some

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are post.

ASSEMBLYMAN HAYES: So all those protocols are in place. But would -- if any of those were violated, it would trigger an individual review of that claim?

INS. GEN. SHEEHAN: The difficulty is that if you pulled every single claim that met those protocols, you would be overwhelmed. So we try to use judgment as well as the automated process.

ASSEMBLYMAN HAYES: The last question I had is, I used the phrase extortion when I was talking about how frustrated many providers have been. Many honest providers have come back and shared with us as legislators about the audit process.

And, you know, I don't know, one man's extortion is another man's extrapolation. And I've heard that term used.

I'm going to give you a very specific example.

A provider will come and report that because it was determined that they made an honest error - in other words, checked an

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2 incorrect box, there was a clerical error, a  
3 decimal point was in the wrong place, that error  
4 was uncovered during an audit. As a result of  
5 that single error being uncovered, your  
6 department would extrapolate and say, if you made  
7 that mistake today, you must have made it last  
8 week, last month. And since you've been treating  
9 this patient for two years, you must have made it  
10 over the course of the last two years.

11 Therefore, we are going to ask  
12 for the reimbursement of the error. We are going  
13 to assign a penalty. And then we're going to  
14 extrapolate that error over the last two years  
15 that you've been filing claims for this  
16 individual. And here's the bill. It's a million  
17 dollars.

18 And the provider says, a million  
19 dollars, that would absolutely bankrupt me.

20 And you say, well, if you give  
21 us \$300,000 and you can give it to us today,  
22 we'll settle the case.

23 Now, two sides to every story.  
24 But there are lots of those kinds of stories that  
25 are floating around out there coming to us as

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legislators from providers.

Can you address that?

INS. GEN. SHEEHAN: Sure. And I'd like to.

I think if you look at the extrapolation, the sampling and extrapolation techniques that are used by the Office of Medicaid Inspector General, they are consistent with the audit and extrapolation techniques used by the Big 4 accounting firms. They're consistent with the extrapolation techniques which the courts and administrative law judges have approved in New York and nationally over the past thirty years.

And we try to exercise good judgment about when extrapolation is appropriate and we have protocols for that.

If it's a single error, I think the provider would come back and say this is why -- this is not typical of our operations and it should not be extrapolated.

But it's important to remember when we have this conversation, there are two separate things going on.

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2 One is we have this trust  
3 system. The claim is submitted. We assume that  
4 what the provider said is true for purposes of  
5 payment.

6 But now we have to go back and  
7 say was the claim properly paid based upon the  
8 records which the provider maintains. Did they  
9 actually do the service? Was it medically  
10 necessary? Was there a physician order because  
11 that's the only control we have on the services  
12 that are provided?

13 And so it's not -- the issue is  
14 not whether they are bad people. The issue is not  
15 whether the penalty should be imposed because the  
16 audit people will not do that.

17 The issue is how much did the  
18 Medicaid program pay for these services and how  
19 much by law should they have paid.

20 And so the -- when I look at  
21 what happened in New York in 2005 where basically  
22 the audit process stopped - all right? - it was  
23 down to, recoveries were down to .2 percent of  
24 the total. There was nothing going on.

25 And I talked to my staff why was

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2 that and what was happening.

3 Well, we were told we should  
4 educate the providers. We shouldn't take money  
5 back.

6 But if you look at the system  
7 that we have in place - right? - which is we rely  
8 on extrapolation, the Federal Inspector General  
9 relies on extrapolation. And the reason we do it  
10 is because the alternative is far worse for the  
11 providers as well as far worse for us.

12 If we were to take two years of  
13 records and say produce these records, the burden  
14 being imposed upon them would be far greater.

15 I've talked to our statistician  
16 who has been doing this work for thirty years.  
17 I've studied the case law in this area. And I'm  
18 confident that our approach is reasoned and we  
19 work hard in making it right.

20 But I don't think you can run an  
21 audit agency that does not rely upon, in the  
22 current environment, that is, before we have all  
23 electronic records, I don't think you can run an  
24 audit agency without using the techniques of  
25 sampling and extrapolation.

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ASSEMBLYMAN HAYES: Two final

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questions.

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You talked about the increase in

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the budget target in the millions, hundreds of

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millions, and now for 2010-2011 it's \$1.1

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billion.

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INS. GEN. SHEEHAN: \$1.2,

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right.

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ASSEMBLYMAN HAYES: \$1.2

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billion.

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Why is that figure going up?

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It's good news that it's going up, but what's the

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cause of it as far as you're concerned? When you

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sit down to do that budget target every year, is

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it because you are getting better or more money

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is being wasted in the Medicaid program?

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INS. GEN. SHEEHAN: I'd like to

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believe it's because we're getting better.

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And this is why when we talk --

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you talk about the ten percent, I think we've

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made huge progress in the last four years in New

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York in addressing these issues.

24

Within OMIG we've gone through

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every business process in the agency or we're in

2 the process of doing it with what we call a  
3 8(h)(1) review, and that's to look at what is the  
4 twenty percent of our effort that's producing  
5 eighty percent of the results.

6 So, for example, we looked at  
7 restrictive recipients. And those are people who  
8 are identified either by county social services  
9 agencies or by others as potentially problematic  
10 patients, you know, we see five different doctors  
11 writing scripts for Oxycotin, for example, and we  
12 restrict them to one physician and one pharmacy  
13 on the theory that they can then manage their  
14 services more closely.

15 We found out that -- we do that  
16 for about I guess about 8,000 people a year, give  
17 or take. And what we said is let's focus on the  
18 ones that cost us the most and let's make sure  
19 that we address them first as opposed to just  
20 doing as they come in.

21 We have a card swipe program  
22 which says that for certain providers who have a  
23 high volume of claims, we want to make sure that  
24 the patient actually produces their card and  
25 swipes at the office because we want to be sure

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the patient was actually there.

And, again, with the machines we say what providers are we likely to see the most, you know, the most change in behavior. We have physicians who are the biggest orderers. We want to make sure they're the ones that are following the rules.

But I think we've gotten much better at being efficient and effective at identifying where the money is spent and trying to find ways to address at the front end.

The other piece that's been very helpful, the Legislature last year passed a bill which allowed us to be much more effective in recovering third party payments. So that's a significant part of our increase as well.

ASSEMBLYMAN HAYES: Last question.

I cited that figure that experts have talked about, anywhere between ten and thirty percent. I know that's a very wide range.

But assuming that we use the smallest part of that range, the ten percent figure, that would in New York bring us up to \$5

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billion. Your target is \$1.2 billion.

First of all, personally, on a personal level, do you believe that ten percent figure is an accurate one?

And, second, if you do, or you are willing to accept the lower end of that range, why kind of resources, if given -- let's say you waved a magic wand and the Legislature gave you all the resources in the world that you needed, could you go out and get it?

INS. GEN. SHEEHAN: Let me just walk through that ten percent number because I've been reading that number since the late '90s.

I was on the National Health Care Antifraud Association's board back in the early '90s. And we got a congressional inquiry in saying what do we think is the level of fraud in the health care system. Remember this is the early '90s which was to me the peak.

So you have a bunch of law enforcement people and insurance people sitting around a table saying what do we think the number is.

And I think we came up with a

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2 number six, but it had no science behind it. It  
3 was an estimate based upon people who, you know,  
4 looked for problems for a living.

5 And we saw that got picked up by  
6 the Government Accountability Office and other  
7 places.

8 And since then, I've tried to  
9 follow the ten percent to see where it comes  
10 from. I think there are three things going on  
11 here.

12 One is, you know, the people  
13 experienced improper billing in their own lives.  
14 I mean if you talk to twenty citizens, every one  
15 of them could come up with an example they have  
16 heard of or have seen themselves. And that  
17 troubles me because it says there's something  
18 we're not reaching.

19 But I think the ten percent was  
20 an overestimate in the early '90s, and I think  
21 there are a whole series of electronic and  
22 investigative controls that have gone in place  
23 since then that make it a lot lower.

24 And in New York I do think the  
25 system is better than the systems I've seen

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2 elsewhere. When I worked with the Federal  
3 government, if you wanted to find out what drugs  
4 somebody was getting, you had to go to system  
5 number one. If you wanted to find out what  
6 managed care things they were getting, you had to  
7 go to system number two. If you wanted to find  
8 out hospital stays, system number three.  
9 Physician services, system number four.

10 New York's system is much better  
11 than, in my opinion, the Federal system in  
12 identifying these things.

13 So I look at these numbers --  
14 so, the issue is what's the percentage. And the  
15 answer is I don't know.

16 We did our survey. Right? And we  
17 found 1.5 percent. Now, of course, that's  
18 providers sending us back the documents. The good  
19 ones send us the documents they have, perhaps the  
20 bad ones send us the documents they make up.

21 But I think that the number is  
22 going to be substantially less than ten percent.

23 And here's the other problem.  
24 The people who commit fraud on the program don't  
25 sit and wait for us to catch them. Right? They

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take the money and they go somewhere else with it or they spend it on defense counsel or they spend it on a variety of other things.

So the first issue is how much -  
- how many improper payments, and then how much fraud is there in the system.

And the second question is how do you get it back and what's your likely recovery rate.

ASSEMBLYMAN HAYES: And the recoveries that are made, are those shared proportionately? Is the Federal government reimbursed and are the county governments reimbursed according to a formula?

INS. GEN. SHEEHAN: Okay.

The way the recoveries are done is we submit a form called a CMS64 to CMS every quarter and it lays out our fraud and abuse recoveries on line 9c.

Within sixty days they take back their share -- they take back their fifty percent.

Most counties are covered by the cap so that the monies they otherwise would have

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gotten they didn't spend. So if it's over the cap, the State takes the entire portion.

ASSEMBLYMAN HAYES: Thank you very much.

ASSEMBLYMAN FARRELL: Thank you.

Senator Hannon.

SENATOR HANNON: I wish my colleague, Senator Johnson, had stayed because I found your explanation good and explanatory and clearing some air.

However, we are going to be doing, Senate Republicans, our own Medicaid Task Force. We were a part of the effort that, and did sponsor of creating your office.

I think we would want to take what you've said this morning and expand it so that we get a better idea of where we can go and how we can do even better.

I noticed in your annual reports you have specific recommendations as to what the Executive and the Legislative Branch ought to be doing to be expanding your effort.

The only thing I wanted to ask

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this morning was just to clarify on the recoveries and the targets.

You have a \$1.2/\$1.3 target in the Executive Budget. There's also the FMAP target.

Do I presume that what portion of the FMAP recoveries that you are responsible for is part of the \$1.3?

INS. GEN. SHEEHAN: The answer is usually.

The FSHRP -- when we talk about FSHRP recoveries, we're really talking about identified amounts due the states. So we may collect -- it may take us a year to collect the money. So the portion that we collect within the year, within the fiscal year, goes towards the budget -- half of that goes towards the budget target, the rest does not until the year that it's actually collected.

SENATOR HANNON: And then the FSHRP program itself was a program by the Federal government to give money to New York State to get recoveries and on the theory that there was a revenue neutrality to it. And then there are

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different targets of monies that you are aiming for as well as MAFUCO, which is the Attorney General's as well as the Department of Health. There are different targets.

But if the State falls short, we get a base amount, and if we reach those targets, we get an additional amount.

So if you don't get your additional amount, we don't get as much money.

INS. GEN. SHEEHAN: It flips around actually, Senator. Governor Pataki got the money. It arranged to be paid beginning in 2006. And part of the consideration for that agreement was that the State would recover an equal amount of money over the next four years.

And what the agreement says is if we don't reach the target for the year, we have to pay back the difference to the Federal government.

SENATOR HANNON: So it's a cost to the State if you don't reach your target?

INS. GEN. SHEEHAN: That's correct.

SENATOR HANNON: Okay.

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Thank you.

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INS. GEN. SHEEHAN: Thank you,

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Senator.

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ASSEMBLYMAN FARRELL: Thank you

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very much.

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Mr. Morelle.

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ASSEMBLYMAN MORELLE: Yes.

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Thank you for your testimony.

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Just a couple brief questions.

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How far back do your audits go?

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INS. GEN. SHEEHAN: The

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statutory maximum I believe is six years. And

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typically the audits, our audits, can go back --

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they can go back six. I think the typical period

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is five.

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ASSEMBLYMAN MORELLE: And if in

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the course of that audit you discover something

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that you think goes beyond the six years, what

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are your powers of auditing beyond that? Is there

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a circumstance under which you can look beyond

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further?

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INS. GEN. SHEEHAN: The

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difficulty - and I'm a recovering lawyer and I

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don't know the statute of limitations for rules

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in New York perhaps as well as I should.

My understanding is if it's beyond six years, it's pretty much precluded from either audit or investigations.

Now, the exception to that is if you are looking at conduct that might be the basis for exclusion, it's a factor that can be considered.

ASSEMBLYMAN MORELLE: I have heard, and I'll go back and check some of the notes in my office of audits that go beyond the six years. So I'm just curious as to that.

INS. GEN. SHEEHAN: If I could.

The exception to that -- the question is where do the six years go back. And the way it works is we will send out a letter saying we are going to do an audit of this time period. And once you send out the letter, if -- the scheduling of the entrance conference is the result of an agreement between the provider and OMIG.

So once -- the trigger for the six years is the letter.

ASSEMBLYMAN MORELLE:

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Understanding that, so if you were to send a letter today, you couldn't look back at a period in 2002, 2001?

INS. GEN. SHEEHAN: I believe that's correct.

ASSEMBLYMAN MORELLE: I was trying to understand from the conversation earlier how is the number derived, the additional \$300 million that the Governor has put in the budget that brings the number I think you said \$1.2 billion?

INS. GEN. SHEEHAN: It's a process not unlike making legislation.

What we do is --

ASSEMBLYMAN MORELLE: Hope it's better than that.

INS. GEN. SHEEHAN: -- we've looked through the information that we have. And so, for example, this year we did these 80/20 analyses of our business processes and the success we've had from the third party payment and how we are doing on audit.

And we tried to reach a number that we feel defensible.

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And typically we'll talk to Budget and they'll say is there room for a little bit more. And we will say, yes, but there are certain things we need to do to get there.

So I guess it's an iterative process. It's a back-and-forth discussion.

ASSEMBLYMAN MORELLE: I thought I heard you say in your testimony that you have to answer for, I'm not sure to whom. Maybe you can tell me. To whom do you answer if you don't hit the \$1.2 billion target?

INS. GEN. SHEEHAN: Well, I serve at the pleasure of the Governor. So at the end of the day I answer to him.

Obviously, the Legislature will have something to say about it too and I would expect that I'd be called here to explain how we got to that problem.

ASSEMBLYMAN MORELLE: An earlier colleague suggested in their questions that they might be uncomfortable with a mandate that you go out and search for fraud, abuse, waste that perhaps didn't exist.

If you got to a point where it

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was not possible to get to \$300 million in additional recoveries --

INS. GEN. SHEEHAN: I would be back to the Governor and the Budget Office and say we're not going to make it, we're not going to make the numbers and here's why.

ASSEMBLYMAN MORELLE: And I must admit I'm a little troubled by it. The targeting makes me uncomfortable in the sense that it seems somewhat arbitrary and it also seems to me as though it's a mandate from the Division of Budget or from the Governor's Office that you will find \$300 million whether it's necessarily there or not.

And you can understand why providers would rightly be concerned about that.

INS. GEN. SHEEHAN: And I do understand that, Assemblyman.

I guess the concern I have is in any business process, you know, any private business, you'll have an allowance for bad debt, you'll have allowances for, you know, increases, you have allowances for insurance.

You try to get your best

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estimates. And, you know, even my -- the city I live in now in Cahoes, you have a budget item for snow removal. Right? You may make it, you may be higher, depending on what happens with the weather.

I think for planning purposes you have to have a number that you set as your objective, and that if you're not going to meet it, there are explanations why. But you want to be able to plan for how are we doing and what do we expect.

ASSEMBLYMAN MORELLE: I wouldn't dispute that.

I thought during the deficit reduction plan we upped the amount of your target numbers. I recall that when we did that in the mid-year numbers. So that was a legitimate just re-estimate. It just happened to be that there was a new target just because --

INS. GEN. SHEEHAN: I'm sorry. Do that --

ASSEMBLYMAN MORELLE: During the deficit reduction act I believe we added -- and maybe my colleagues recall better than I do -

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- I thought it was \$150 million. But even if it were \$50 million, it just seems to me that in the middle of a year for us to suddenly re-estimate -

INS. GEN. SHEEHAN: Well, it wasn't done without our knowledge and consent.

And as I -- we think that several of the things that we've done worked out better than we had anticipated at the beginning of the year.

And so we knew half way through the year we could look at those numbers and say here's where we are.

ASSEMBLYMAN MORELLE: So that number then simply plugged in what your best guess of where you would be at the end of the fiscal year then.

INS. GEN. SHEEHAN: We were asked to say what else could we do and we came back with the information to support it.

ASSEMBLYMAN MORELLE: So without additional resources at mid-year you would not have gotten to that number?

INS. GEN. SHEEHAN: I - that's

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a fair question. I'd have to think about it.

If you tell me to run faster,  
and if you tell my staff to run faster, we'll  
keep running faster as long as we can.

ASSEMBLYMAN MORELLE: But I  
only want you to run faster if it's fair and  
legitimate to ask you to run faster. I don't want  
you to run faster -- I mean I think we're all --  
you know, the comments you've heard and they're  
certainly not uniform, but I suspect if you had  
212 legislators here, 210 could tell you that  
they've heard voiced thoughtful, legitimate  
concerns from providers back in their  
communities, not-for-profit organizations doing  
the best they can but who are very, very  
concerned about the auditing process.

Now, I'm not involved in it  
first-hand so I can only tell you that I've heard  
enough of it though from people that I consider  
running very high quality, in a sense providing  
public service, not-for-profits, that it troubles  
me.

And I would like to learn more  
about the process. So I appreciate the chance to

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have this conversation.

And it also seems to me that in time if you're doing your job well, and I'll assume that you are, that over time two things would happen. One, you would be weeding out all the bad actors; and, two, that you would have put the fear of God in everyone so over time those recoveries ought to decline.

I haven't seen those numbers decline.

INS. GEN. SHEEHAN: You and I are on the same page on that. And that's why we are -- why the mandatory compliance thing we think is making a difference.

Most of the audits we're doing now are going back to 2005, '06, '07, '08. So we think if you look a year or two down the road, we are going to see a decline in recoveries because there will be more compliance.

And I think we're already starting to see that in terms of the behavior of providers in New York State.

ASSEMBLYMAN MORELLE: Well, I don't want to belabor this and I do want to let

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others speak and get to the next witnesses.

But I want to come back to you maybe offline about this. I'm really hearing things that trouble me.

And I think it's -- you know, when I think of the logistical conclusion of some of this, if I were a traffic enforcement officer and I stood at the end of my street and just watched quietly and counted the number of people that did rolling stops at the stop sign, I probably could go back to everyone on the street and say I'm going to assess you because I've extrapolated that thirty percent of the vehicles on this street don't stop at the stop sign.

It may be stretching the logical a little, but I mean, you know, we could get into a position where we're just assessing people based on some statistical number. And I'm not sure I'm comfortable with that entirely.

INS. GEN. SHEEHAN:

Assemblyman, I'd be very happy to sit down offline with you and just walk through the techniques that we use. The basis we think makes sense for what we're doing.

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2 Remember, it's not -- it's not  
3 everybody on the street. It's your entity, you  
4 know, you and your car. If we watch you and  
5 thirty percent of time you do rolling stops, I  
6 don't think it's unfair to say that probably,  
7 assuming it's random, is a reasonable way to tell  
8 what you're doing.

9 ASSEMBLYMAN MORELLE: Well, I  
10 appreciate that.

11 I also think in some of these  
12 cases organizations have different leadership and  
13 have changed over over the period of five or six  
14 years. It could be said to be new owners in the  
15 house or new people on the street.

16 So I'm aware of it. And, again,  
17 I don't belabor it. But I would like to come back  
18 to you and perhaps figure out a way to share with  
19 you when I hear stories.

20 And I think as my colleague Mr.  
21 Hayes said, there are always two sides to the  
22 story. But some of these are from folks that have  
23 been very trustworthy, have great reputations in  
24 our communities who have expressed some real  
25 concern about it. And I'm sure you would want to

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hear that as well

INS. GEN. SHEEHAN: I would appreciate the opportunity to do that.

And I mean to me the thing about the work that we do is we need people to be comfortable that the activities that we do are legitimate and the explanations make sense.

And so the more we can hear about that, and I think, you know, reaching out to you and your constituents would make sense for us too.

ASSEMBLYMAN MORELLE: Thank you, sir.

ASSEMBLYMAN GOTTFRIED: Well, we're really in trouble.

Mr. Hayes, as he was stepping out, leaned over to me and said you're in charge.

So I'll call on myself.

And I don't really have a question. I just want say that I think that the concerns that Senator Johnson and Assemblymember Morelle and others have voiced, I have heard from a similar broad range of providers, and, as Mr. Morelle said, people whose upstandiness I would

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ordinarily have confidence in.

And I understand that a variety of organizations are developing or have developed a legislative proposal based on what they feel they have experienced which they will be, I trust, shortly bringing to us.

And I think if in the budget we are going to be acknowledging, raising, whatever you want to call it, a higher level of expectation of what your efforts will produce, I think at the same time it will make sense to work through some of those legislative proposals, certainly in consultation with you and the Executive Branch generally to make sure that the operation is functioning in a fair and reasonable and accurate manner.

INS. GEN. SHEEHAN: And I appreciate that, Chairman Gottfried.

I think it's important not for us to wait for the legislation, but understand what legitimate issues people have and to make sure we're responsive to them.

And we are prepared to do that and we hope we have done that in the past. But we

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want to hear what their concerns are.

ASSEMBLYMAN GOTTFRIED:

Questions?

(No response.)

ASSEMBLYMAN GOTTFRIED: Okay.

Well, then thank you.

I think the next witness then  
will be Troy Oechsner, I believe.

INS. GEN. SHEEHAN: I thank the  
Committee and the Chairman.

ASSEMBLYMAN GOTTFRIED: Thank  
you.

MR. TROY OECHSNER: Thank you.

I guess there was a  
miscommunication. I'm actually not here to  
testify. I was here to support Dr. Daines and  
answer any questions that you have about the  
proposal in the budget to restore the Insurance  
Department's authority to regulate health  
insurance premium increases.

So -- yes, I am Troy Oechsner  
with the New York State Insurance Department.

ASSEMBLYMAN MORELLE: Could you  
just explain the proposal?

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MR. TROY OECHSNER: Sure.

The -- as Assemblymember Morelle knows, we've had prior -- a proposal to restore prior approval for a number of years. And there's a lot of reasons on the merits to support it.

This year it's made it into the budget. So I'll just refer to my testimony before Assemblymember Morelle and written testimony. We've also issued a report on the policy reasons to support prior approval.

But as to the specific budget proposal, the fundamental idea is that -- and I'll give you the real quick version. If you want to ask me to go into it, --

ASSEMBLYMAN GOTTFRIED: Please.

MR. TROY OECHSNER: -- I'm happy to do it.

But the basic premise is that rate increases for premiums will be less under a regulated prior approval regime. As a result, fewer people will drop coverage, employer-based, sponsored coverage. There will be fewer uninsured and fewer of those people who are uninsured will sign up for public programs, and that will result

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in savings to public programs.

So that's the basic premise.

I'm happy to go through each of those steps and talk about how we got there.

ASSEMBLYMAN GOTTFRIED: Well, why don't we leave it in case anybody has any questions. I think --

Does anybody have any questions?

ASSEMBLYMAN MORELLE: Yes.

ASSEMBLYMAN GOTTFRIED:  
Assemblyman Morelle.

ASSEMBLYMAN MORELLE: Thank you, Mr. Chairman.

Troy, thank you for being here.

I do want to walk through the methodology a little bit.

First of all, the proposal in the bill advanced to us by the Governor has an effective date of October, 2010; is that right?

MR. TROY OECHSNER: Correct, yes.

ASSEMBLYMAN MORELLE: So do the rates then, which are typically produced by insurers after, I assume, sometime in June or

1  
2 July they start to look at the actuarial data and  
3 start to form their judgments about rates going  
4 into the what will now be the 2011 calendar year.

5 So if this proposal goes into  
6 effect in October, is it the intent then of the  
7 Department or the Second Floor that the 2011  
8 rates would undergo a prior approval process in  
9 order to have the budget number work out?

10 MR. TROY OECHSNER: No. And the  
11 savings would be -- result primarily of the  
12 increased medical loss ratio for the first year.  
13 There's less savings this year than there would  
14 be in, you know, out years. So --

15 ASSEMBLYMAN MORELLE: Wait.

16 So the savings in the third --  
17 what essentially would be the last -- well, let's  
18 call it the last five or six months of the fiscal  
19 year, the October, November, December, and then  
20 the first quarter. So that's six months, half-a-  
21 year. Right.

22 MR. TROY OECHSNER: We would be  
23 asking plans to increase their MLR immediately  
24 for the remainder of -- you got to understand  
25 because not everybody is on a calendar year the

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way they do their rates.

So those people by October 1st that need to come into compliance would do so.

Those people -- those plans that are going to be increasing their rates for the new year would be subject to -- for 2011 would be subject to prior approval. They increase the MLR in the bill.

SENATOR HANNON: Why does prior approval involve MLR? What's your mechanism?

MR. TROY OECHSNER: Why does prior approval involve MLR? Well, the medical loss ratio is the test that is used to ensure that, how much of the premium dollar is being spent on medical claims.

Right now it's seventy-five cents out of every dollar for a small group, and eighty cents out of every dollar for individual plans.

The proposal would increase that to eighty-five --

SENATOR HANNON: Where does this seventy-five cents and eighty-five cents come in? How is that established? Is that current

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regulation?

MR. TROY OECHSNER: Yes.

Seventy-five and eighty percent is current law, yes, under file and use. That's what they're supposed to meet at the end of the year.

And what this proposal would do is, among other things, increase that medical loss ratio to eighty-five percent.

ASSEMBLYMAN MORELLE: I'm sorry.

So what you said earlier was, in the first comment you made, was that the rate increases, which typically you would see under a file and use system are higher than what you anticipate under prior approval and, therefore, the budget number is determined by the difference between those two and then the subject number of fewer people that would go from private insurance into some publicly supported program.

MR. TROY OECHSNER: Correct.

ASSEMBLYMAN MORELLE: But what you just said now about the \$70 million dealt more with the MLR than the prior approval. So I

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2 was trying to understand the number.

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MR. TROY OECHSNER: It's both.

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It's both the MLR, you know, in the short run. In

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the long run it's going to be both the MLR and

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prior approval.

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ASSEMBLYMAN MORELLE: So for

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this fiscal year, though, 2010 to 2011, of that

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\$70 million how much would you attribute to

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increased MLR versus the prior approval system?

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Do you know?

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MR. TROY OECHSNER: I don't

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know that off the top of my head. I can get that

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to you.

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We did do a breakdown for the

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budget. And you would think I'd have that off the

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top of my head, but I don't. But I can get that.

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ASSEMBLYMAN MORELLE: And

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roughly how many policies follow the calendar?

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Isn't it the vast majority? Aren't they on the

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calendar year?

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MR. TROY OECHSNER: The

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majority do follow the calendar, but a

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substantial number do not. You know, small

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groups, others come in at various times of the

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2 year. So it certainly isn't everybody that's on a  
3 calendar year.

4 ASSEMBLYMAN MORELLE: So -- and  
5 I don't want to belabor this, but for those who  
6 will have policies that begin roughly in October,  
7 they will be subjected to a new MLR, which means  
8 that they will have to have a different rate  
9 potentially because if they have fixed  
10 administrative costs, now they are going to have  
11 to deal -- somehow they are going to make some  
12 significant changes. And typically we would give  
13 them a year's period of time to submit rates,  
14 have the rates approved, et cetera.

15 That's not going to happen here  
16 presumably. Is that what you are suggesting?

17 MR. TROY OECHSNER: Well, I  
18 mean you're right, that by having the take-up  
19 time soon is going to put more pressure on admin  
20 costs and profits. And those are the two basic  
21 components of the non-MLR piece of the insurance  
22 pie.

23 ASSEMBLYMAN MORELLE: And for  
24 those that are going to now go through the prior  
25 approval system, aside from the MLR issue, but

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are now going to submit rate requests to the Department, for what period will the first group of policies have to submit to the Department?

So if you're a calendar year and typically rates come out beginning in November, sometime in early November, if the effect of this section is October, will insurers who are applying for -- will they now have to apply for rates in October and have them approved for January 1 policy renewals or new policies in January?

Or will they not go -- will that system not be effective until the 2012 rates?

MR. TROY OECHSNER: You know, prior approval will be starting for 2011.

ASSEMBLYMAN MORELLE: So that happens --

MR. TROY OECHSNER: If I understand your question.

ASSEMBLYMAN MORELLE: Well, let's say you're an insurer and you get your actuarial -- let's -- for the policies that begin January 1st. Typically you would go through a data collection process, presumably sometime in

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2 July or August you start to look at rate setting  
3 or you submit a rate request to the department,  
4 and then the department will have some time to be  
5 able to approve those, and then by sometime in  
6 November you have to let employers and  
7 individuals know what the rates are going to be  
8 so they can select a particular policy that they  
9 want.

10 MR. TROY OECHSNER: Correct.

11 ASSEMBLYMAN MORELLE: So given  
12 that this is going to be an October effective  
13 date, and since most of that work will have  
14 already been done, is it the intention of the  
15 department to start making -- to start an  
16 approval process for policies that will be in  
17 effect on January 1st?

18 Because it seems like the time  
19 line just simply doesn't work.

20 MR. TROY OECHSNER: Yeah. It's  
21 a compressed time line and we're going to have to  
22 work really closely with the industry to try and  
23 get that piece of it done, yes.

24 ASSEMBLYMAN MORELLE: But just  
25 so I understand.

1  
2                   Typically you would be about  
3 thirty days away from releasing to employers and  
4 individuals what the rates are, and this year you  
5 won't even have begun the prior approval process;  
6 is that right?

7                   MR. TROY OECHSNER:     In the  
8 current year coming up -- in 2011 you're talking  
9 about now --

10                  ASSEMBLYMAN MORELLE:     Yes.

11                  MR. TROY OECHSNER:     -- where  
12 the intention is to begin prior approval.

13                  I mean I think your question is,  
14 is it going to be a tight timeframe. And the  
15 answer is yes, which is part of the reason why  
16 we've asked for some additional resources. And  
17 we've talked about it internally to see where we  
18 can pull resources from existing staff to make  
19 this happen. It's stuff -- it's going to be an  
20 all-hands-on-deck. But we're committed to making  
21 it happen and we believe we can.

22                  ASSEMBLYMAN MORELLE:     So let me  
23 just touch upon that and then I'll relinquish the  
24 microphone.

25                  When it comes to the number of

1  
2 individuals necessary to do prior approval, can  
3 you give an estimate of how many rate requests  
4 you would expect and what the current staffing  
5 allocation is for that and, finally, how you --  
6 what's the plan to be able to do this in the  
7 timeframe that allows people to have rates by  
8 January 1st?

9 MR. TROY OECHSNER: Yes.

10 Well -- and I can have somebody  
11 give us a more much detailed breakdown. But  
12 basically we're expecting somewhere in the nature  
13 of a hundred and fifty applications. But we've  
14 been talking about working with the industry to  
15 try and consolidate some of those applications  
16 into different groupings.

17 We have some six actuaries that  
18 would be committed fully to doing that review as  
19 well as over a dozen examiners who would be  
20 assisting the actuaries in doing some of the non-  
21 actuarial work that needs to be done on that.

22 And the turnaround no doubt is  
23 going to be tight. But, again, I trust my folks  
24 and I would not want to put them in a position to  
25 fail. So I'm told by our -- Gene Binsky

2 (phonetic), the head of our bureau, that we will  
3 be able to do it. It's going to be tight, but we  
4 are going to be able to do it.

5 ASSEMBLYMAN MORELLE: I beg the  
6 indulgence of the Committee. I had said I would  
7 ask one more question. I'm going to ask one more.  
8 I'm going to do what Mr. Hayes did. He actually  
9 asked three last questions the last time I  
10 noticed. So I've got two more in reserve.

11 Aside from the budget number, or  
12 maybe this is the answer, the necessity for a  
13 number in the budget, wouldn't -- with the  
14 concern I think that has been expressed by a  
15 number of folks about the staff allocated to do  
16 this and the number of applications and the  
17 timing, all those three factors together, why  
18 wouldn't this make more sense to institute it for  
19 the 2012 rates in January and basically give  
20 everyone a year to acclimate to a new system?

21 Is it simply the budget  
22 pressures or are there other reasons to do that?

23 MR. TROY OECHSNER: Well,  
24 certainly the -- it would be less savings to the  
25 budget, which is one obvious reason.

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2 But the bigger reason is that  
3 consumers, small businesses, are hurting out  
4 there. And we think that to the extent we can  
5 ensure that no improper rate increases, excessive  
6 rate increases, cause people to drop coverage  
7 right now, the sooner the better.

8 I guess that's the main reason.

9 You know, granted if we had a  
10 year, two/three years out, it would be easier to  
11 plan. But I think the sort of moral and policy  
12 imperative to get this done now drives us to work  
13 hard to make it happen as soon as possible, in  
14 addition to the budget savings.

15 ASSEMBLYMAN MORELLE: Thank  
16 you, Mr. Chairman.

17 ASSEMBLYMAN FARRELL: Thank you  
18 very much.

19 Are there other questions?

20 Kemp Hannon.

21 SENATOR HANNON: Good afternoon.

22 I might come back to the  
23 ability, if you're able to do it. But I would  
24 like to just run through, because I found it a  
25 little bit difficult to grasp how this actually

1  
2 will result in savings for the budget that we're  
3 discussing. That would be the one, April 1, 2010,  
4 the next twelve months.

5 Your -- this will not be  
6 implemented until there are plans approved for  
7 January 1, 2011.

8 MR. TROY OECHSNER: Prior  
9 approval. The MLR will go up in October, yes.

10 SENATOR HANNON: October 1.

11 MR. TROY OECHSNER: Yes.

12 SENATOR HANNON: Okay.

13 So that MLR would be worth six  
14 months of the current fiscal year, and prior  
15 approval would be worth three months.

16 MR. TROY OECHSNER: Well, I  
17 don't know -- it depends. If a plan is going to  
18 be renewing on October 1st, we would want prior  
19 approval for those plans starting in October 1st.

20 But for the most part, yes.

21 SENATOR HANNON: So how many  
22 plans are there that would be subject to your  
23 proposal?

24 MR. TROY OECHSNER: How many --  
25 it depends on what you mean by "plan." How many -

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SENATOR HANNON: It's your  
proposal. It's your proposal.

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MR. TROY OECHSNER: -- covered  
wise?

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SENATOR HANNON: Currently you  
have file and use as an existing law of the  
State.

10

MR. TROY OECHSNER: Right.

11

SENATOR HANNON: How many  
people file and use in this State every year for  
health care insurance in this State?

14

MR. TROY OECHSNER: Are you  
talking about the number of filings that we get  
from insurance companies or the number of people  
who are covered by those plans?

18

SENATOR HANNON: No. I'm  
talking about the number of plans who are filing  
-- file and use under the statute that you  
purportedly administer.

22

MR. TROY OECHSNER: Currently,  
let's say 2009, I don't have the exact -- I  
should have it but I don't have the exact number,  
but I can get back to you on the exact number.

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SENATOR HANNON: What is it? Is it a hundred? Is it five hundred? Is it a thousand?

MR. TROY OECHSNER: It's less than thousand and less than five hundred, but it's more than the hundred and fifty that we talked about is my recollection.

But what we -- as I said to Assemblyman Morelle, what we are talking about doing is working with the industry, issuing some guidance to try and consolidate some of those filings.

SENATOR HANNON: So people will file when? So you have about somewhere between five hundred and thousand filings representing how many plans? Does one company file for all their plans at once?

MR. TROY OECHSNER: Well, for those plans that are subject to prior approval --

SENATOR HANNON: No, no. Plans right now who are subject to file and use. Every plan that wants to run a state-approved health insurance plan in this State must file file and use; is that correct?

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MR. TROY OECHSNER: Correct.

SENATOR HANNON: Okay.

So you know how many are filed.

MR. TROY OECHSNER: Well, I shouldn't say that. There are some plans right now who do have to submit prior approval applications if it's a brand new form, --

SENATOR HANNON: So that would be in addition --

MR. TROY OECHSNER: -- policy form.

SENATOR HANNON: -- to the ones who do file and use?

MR. TROY OECHSNER: In addition to the current number that are being currently in file and use right now? I don't understand your question because --

SENATOR HANNON: Well, you just told me -- you told me that there's somewhere between five hundred and thousand.

MR. TROY OECHSNER: No. Less than five hundred, we believe.

SENATOR HANNON: The people who do file and use in this State, you told me

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there's somewhere between five hundred and a thousand.

MR. TROY OECHSNER: No. I believe it's less than five hundred filings.

SENATOR HANNON: Less than five hundred.

Now, how did you mention a thousand? You told me less than a thousand.

MR. TROY OECHSNER: You said was it less than a thousand, and I said yes. You said was it less than five hundred. I said yes.

SENATOR HANNON: So how many people have to get prior approval now in the State and how many do it each year? What's the average?

MR. TROY OECHSNER: The average number of prior approval applications? Right now I don't know the exact number, and, again, I can get that for you as well. But I believe it's fifty or less.

SENATOR HANNON: So let me just go a little bit different.

The computation -- because I'm not looking at the wisdom of the insurance and

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the wisdom of what will happen to the individual premium holder. I'm looking for how this impacts the State's budget.

Currently your proposal would purportedly save \$70 million of the State's expenditures.

MR. TROY OECHSNER: Correct.

SENATOR HANNON: That would be State dollars.

MR. TROY OECHSNER: Yes.

SENATOR HANNON: That would be Medicaid?

MR. TROY OECHSNER: Medicaid, Child Health plus Family Health Plus, yes.

SENATOR HANNON: So usually we can double that. So it would be perhaps \$140 million in savings because Medicaid --

MR. TROY OECHSNER: No, because some of that is Federal money, yes.

SENATOR HANNON: Well, the State's share is usually about fifty cents.

But, yes, it's a Federal share. \$140 million.

MR. TROY OECHSNER: Right.

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SENATOR HANNON: How does the fact that you have prior use reduce that much money in Medicaid?

MR. TROY OECHSNER: The premise is that, in talking with our actuaries and looking at the history of rate increases, both before prior approval and after prior approval, we believe that there would be about a three percent lesser rate of increase under prior approval than there would be pre-prior, than there would be without prior approval, under file and use.

And we base that on -- I don't know how much you want me to go into the basis for that, but we base it on --

SENATOR HANNON: Not only do I want to go into the basis, I'd like to find where that study might be available.

MR. TROY OECHSNER: Well, the study is based on discussions with our actuaries which look at the rate increase before -- rate increases before prior approval, the rate increases after, comparable national rate increases with, and medical inflation rates, and

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also look at the contribution of the increase in the MLR, all to that mix, and came out with a conservative estimate of about three percent less rate increase.

So we looked at, for example, when rate -- before prior approval rate increases were about five percent before full implementation of --

SENATOR HANNON: Before prior approval rate increases averaged --

MR. TROY OECHSNER: About five percent.

SENATOR HANNON: -- five percent.

MR. TROY OECHSNER: After -- since 2000 and full institution of prior approval, rate increases have been about fourteen percent, 13.9 percent.

SENATOR HANNON: Don't you have this reversed.

MR. TROY OECHSNER: What?

SENATOR HANNON: Aren't you reversing this?

MR. TROY OECHSNER: Maybe I

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misstated.

But after -- I'm sorry. After institution of file and use, after deregulation - I apologize if I misspoke - since deregulation of rates in 2000, rates have gone up about fourteen percent, 13.9 percent.

Now not all of the difference between five percent before deregulation and fourteen percent after deregulation, not all of that is attributable solely to the deregulation. But our actuaries believe a good three percent minimum was attributable to that and could be booked as savings.

SENATOR HANNON: So three percent of the increases was attributed to the lack of prior approval.

MR. TROY OECHSNER: Correct.

So then if you look at a study that was done -- the insurance industry cites quite often by Donna Novak, New York State Mandated Health Insurance Benefits, they talk about a one percent increase in rates yields about 30,000 people who end up dropping coverage because, of course, there are always certain

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people who are right on the edge of being able to afford coverage, who are very price sensitive, particularly in the small group market.

And there's also a Lewin study that we used.

There's a Health Affairs article called "It's the Premium, Stupid: Projections of the Uninsured through 2013."

We used a number of things that all came in in a, you know -- so we thought about --

SENATOR HANNON: Could you let us -- share that with us.

MR. TROY OECHSNER: Sure.

I don't want to go too much in the weeds and take up too much of your time here.

But --

SENATOR HANNON: It's my time. I'm asking the questions. I'm going to be here to whatever. So just feel free. I would like to get those documents.

But I really want to go through.

You're talking about if you increase benefits to a premium holder or to a

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policy holder, then there's an increased cost and people tend to stop having health care coverage.

MR. TROY OECHSNER: Correct.

Mostly in small --

SENATOR HANNON: That's all because of the cost to the individual, is it not?

MR. TROY OECHSNER: It's the cost to the individual or the group, the employer, small employers.

SENATOR HANNON: Okay.

But those are all costs.

Now, what I'm trying to do for this budget is to try to figure out how those costs translate to people going and getting Medicaid.

MR. TROY OECHSNER: Correct.

SENATOR HANNON: Now, do you administer Medicaid at all in the Insurance Department?

MR. TROY OECHSNER: We do not, but we work very closely, of course, with Donna Frescatore and all the people in the Department of Health whom we looked at at this proposal --

SENATOR HANNON: So you're

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familiar with how one applies for Medicaid?

MR. TROY OECHSNER: It's not my area of expertise. I'm a commercial insurance --

SENATOR HANNON: But you work closely with the people who do.

MR. TROY OECHSNER: Correct.

SENATOR HANNON: So you have available to them and presumably in formulating this proposal you consulted with them.

MR. TROY OECHSNER: We did, yes. As well as the Division of Budget.

SENATOR HANNON: Is it not true that Medicaid is an income-based eligibility system?

MR. TROY OECHSNER: It is.

SENATOR HANNON: So how does not having a health plan relate to people's income?

MR. TROY OECHSNER: Well, --

SENATOR HANNON: Isn't it the reverse? If you drop your health care premium, you'll have more money.

MR. TROY OECHSNER: Well, we're looking at a number of studies, one by the Center

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2 on Budget and Policy Priorities and a number of  
3 others that have basically shown a link between  
4 people who get priced out of coverage because  
5 their premiums get too high - largely, low-wage  
6 working people and small businesses - lose their  
7 coverage and are eligible, some of them,  
8 certainly not all, but some of them are eligible  
9 for public programs, and some of those sign up  
10 for public programs. That's the basic premise.

11 SENATOR HANNON: Would it  
12 surprise you to know that from our task force  
13 studies that half of the people in this State who  
14 don't have health insurance are eligible for  
15 Medicaid?

16 But the other half are not  
17 eligible for Medicaid.

18 So that the correlation - and  
19 that's pretty much been the case for a decade.

20 MR. TROY OECHSNER: Correct.

21 And -- if you want me to  
22 continue, I'll continue. But we calculated that  
23 in, that not everybody certainly who would lose  
24 coverage would be eligible and sign up for public  
25 programs.

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SENATOR HANNON: But I'm still trying to struggle with: if you lose eligibility for health insurance, how that translates into affecting your income, your income being the determination as to whether or not you're eligible for Medicaid.

MR. TROY OECHSNER: Right.

I think the basic --

SENATOR HANNON: Linking is okay. But I'm talking about the direct mechanism, because you then are booking -- you just said before, \$140 million in terms of total aspect, Federal and State, --

MR. TROY OECHSNER: Right, right, right.

SENATOR HANNON: Okay?

-- \$140 million. That's not even for a full fiscal year. You're talking about probably over, doubling it, just roughly doubling it, a \$280 million effect for prior approval, which begins to stretch how I can follow this whatsoever.

MR. TROY OECHSNER: Well, again, you know, if you want to dispute the

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numbers, you can. But I'm telling you the basis of it is that we estimate it from three percent savings of less rate increases from instituting prior approval. There would be a certain number of people who would drop coverage, about 90,000.

We estimated that about 20,000 of those would be eligible and sign up for either Medicaid, Child Health Plus, Family Health Plus or Healthy New York, one of --

SENATOR HANNON: Where did their income change?

MR. TROY OECHSNER: Some of them may -- some of them would be eligible for public -- as I'm sure you know, there's many people who might be eligible for public programs because they're very low wage workers, but who don't -- haven't signed up for coverage, but -- because they have employer-based coverage.

SENATOR HANNON: So you're not saying their income changes. You're saying that they have a dual eligibility. They're going to take advantage of the second eligibility.

MR. TROY OECHSNER: Certainly many of them would, yes.

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2 SENATOR HANNON: And did you  
3 factor in the fact that we increased the ability  
4 to get eligibility last year in last year's  
5 budget?

6 MR. TROY OECHSNER: My  
7 understanding is that, yes, when we talked to the  
8 folks in the Department of Health and Division of  
9 Budget making our estimates, that was taken into  
10 account.

11 SENATOR HANNON: So could we  
12 get those computations so we can take a look at  
13 that?

14 Because, yes, it is a question  
15 of quibbling and budget, but this is a huge  
16 amount of money. I mean we do other things that  
17 we put -- there's a proposal for a HICVA tax or  
18 elimination of trends, and they're in the  
19 millions of dollars, but at least you can  
20 ascertain what this is.

21 This is -- I don't believe --  
22 you've had this proposal for prior approval for a  
23 number of years, have you not?

24 MR. TROY OECHSNER: Not in the  
25 budget, but, yes, we have had it.

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SENATOR HANNON: Not in the budget.

But when you've had it before, were there ever cost savings attached to it?

MR. TROY OECHSNER: We did not do it as a fiscal in the past.

SENATOR HANNON: So this is the first time we've seen cost savings attributed to it.

MR. TROY OECHSNER: Yes.

SENATOR HANNON: That probably wasn't your choice since you're so comfortable explaining.

MR. TROY OECHSNER: Not true.

SENATOR HANNON: Thank you, Assemblyman Farrell.

ASSEMBLYMAN FARRELL: Any further questions?

Mr. Baccalles.

ASSEMBLYMAN BACCALLES: Are insurance companies on a schedule to send their rate increases to you now? I mean do they come July 1, some come January 1, some come October 1?

I mean is there anything that --

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I mean do they do it on an annualized basis?

MR. TROY OECHSNER: Well, currently, a health plan merely needs to submit a notice to us because it's file and use. So there's no prior approval.

But if they want to increase their rates, they just submit a notice to us. And it needs to be thirty days in advance of the rate increase becoming effective and going out, and they have to send notice to their --

ASSEMBLYMAN BACCALLES: To their subscribers?

MR. TROY OECHSNER: -- to the subscribers, yes, to the policyholders.

ASSEMBLYMAN BACCALLES: The reason for my question, is there anything to stop health plans from -- I mean, from every health plan in the State of New York that does business here sends you a rate increase September 1 to be effective October 1.

You know, by you saying that it's going to start, prior approval is going to start October 1, aren't you really just saying, okay, we'll just send it to them August 31st to

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2 start September 30th, beats the October 1  
3 deadline. And then they won't send you another  
4 rate increase for another year or eighteen  
5 months.

6 In other words, they can send  
7 you a rate increase a month in advance of your  
8 imposed start of file and approval.

9 MR. TROY OECHSNER: Yeah.

10 And we're going to have to work  
11 out a timing system working with the industry to  
12 make sure that, you know, they have enough time  
13 to work it in and we have enough time to review  
14 it.

15 But, you know, essentially, yes,  
16 they're going to be working on their rates.  
17 They're collecting data from last year.

18 ASSEMBLYMAN BACCALLES: I just  
19 thought maybe you might shorten up the deadline  
20 so that they wouldn't -- you know, I mean they're  
21 going to have almost a year, six months to file a  
22 rate increase. And, you know, they're just  
23 jacking up early, do what the credit card  
24 companies did with the Federal legislation that  
25 put controls on them. You know, do whatever they

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want to do before the new regulations go in place.

Okay. Thank you.

ASSEMBLYMAN FARRELL: Any further questions?

(No response.)

ASSEMBLYMAN FARRELL: Thank you very much.

MR. TROY OECHSNER: Thank you.

ASSEMBLYMAN FARRELL: Greater New York Hospital Association, Kenneth E. Raske, President and CEO - 12:10.

MR. KENNETH E. RASKE: Thank you very much, Mr. Chair, and Members of the Joint Committee.

I am here as President of the Greater New York Hospital Association, and it's always a privilege to appear before you annually to talk about the budget.

Am I on?

ASSEMBLYMAN FARRELL: No, you're not.

MR. KENNETH E. RASKE: Am I on now?

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ASSEMBLYMAN FARRELL: You're on  
now.

MR. KENNETH E. RASKE: All  
right. Thank you.

So what I would like to do is,  
first, to express my gratitude to the Executive  
Branch - yes, I'll repeat - my gratitude to the  
Executive Branch on a couple of matters of great  
importance to the Greater New York Hospital  
Association.

The first is that in the just  
released 21-day amendments the Executive Branch  
has removed some highly problematic reimbursement  
formula adjustments that create massive  
redistribution of funds throughout the health  
care system, and in many cases for those that  
were damaged by the budget cuts, it significantly  
amplifies the damage.

So my thanks to the Executive  
Branch for doing that and not creating more  
difficulty for an already stressed system.

The second thing I want to  
publicly acknowledge the Executive Branch, and  
actually Senator Duane, you're party to this as

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2 well, as well as your colleague, Dick Gottfried,  
3 as well as a number of elected officials, is the  
4 hard work that the task force is doing to try to  
5 save St. Vincent's Hospital on the westside of  
6 Manhattan.

7 The Executive Branch has made  
8 that a commitment to work that through, and it is  
9 his task force that he's put together. And we are  
10 privileged to be on it too.

11 I don't know where this will  
12 take us, but it's an important step.

13 So those thanks aside, may I get  
14 directly into the budget.

15 There is a document which is  
16 appended to our testimony, our written document.  
17 It's a blue document. And I'm not even going to  
18 go through all of the panels there because that  
19 would be laborious and you've already had a long  
20 morning and early afternoon, and some very  
21 important people, including Dan Sisto behind me,  
22 that need to testify.

23 But what I'd like to do is just  
24 walk you through a couple of those slides that  
25 are of great importance to us.

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If I could turn you to page ten, panel ten, of the slides, here we show in these pictures two things of great consequence to the hospital community.

One is their total operating margin. Profitability is another word for it.

The other one is equity financing ratio trend, which is how much money you put down on a building or a major movable.

And what I've done in these two pictures is show the U.S. behavior pattern versus New York. And in both cases New York is well below the U.S. and tanking.

Notice the decline that we see in the most recent years. The drop is significant.

And it is induced in large part due to the current recession and the budgetary woes that we are experiencing.

If I can now take you -- and if you have any questions, Mr. Chairman, please stop me and I will attempt to answer any questions that you might have.

ASSEMBLYMAN FARRELL: No. It's

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your call.

MR. KENNETH E. RASKE: Okay.

Thank you, sir.

If I can now move you forward to page three.

Medicaid expenditures continue to grow. And I know it's frustrating for the elected officials that are before me and those of your colleagues in both bodies. But there is no rocket science in the analytical sense of why Medicaid expenditures are as much as they are.

Basically, chart three tries to just decompose the component factors.

It turns out that real spending on Medicaid per recipient is declining and it has been declining. But what hasn't been declining is the growth in eligibility. This is  $P$  times  $Q$  in basic Econ101: price times the quantity of services.

And when you have that kind of enrollment growth in large part due to the severe recession that the U.S. economy and we, as a subset, are in, well, you are going to have this kind of stuff going on.

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But the real impact on a per resident amount is actually dropping and substantially.

Go to the next panel, which is panel four. And these data are from the Division of Budget. So they're not coming -- all we did is put them in a bar chart form. But it's really interesting.

What we've done is we put the unemployment rate of the State annexed to the Medicaid eligibility. And no surprise, ladies and gentlemen, the fact of the matter is that as unemployment increases, so does eligibility.

But what comes up must come down. So if you take a look at the year 2011 projections, 2012, these are fiscals, and 2013, as you see, there is significant relief in Medicaid spending on the horizon in large due for the factor that I just cited, the number of people eligible will drop because the number of people employed and, therefore, having insurance will increase.

Now, if this does this in this upcoming fiscal year, it would be pretty -- it

1

2 would be a great thing for everybody, every  
3 citizen of the State as well as the State  
4 government. But this is something that we are  
5 looking at very carefully.

6

7 It may be - and I would ask you,  
8 Mr. Chairman, to have your staff take a look at  
9 it, at the DOB numbers because it's kind of  
10 important. I think buried in this is the  
11 eligibility estimates and how much cushion there  
12 might be built into overall Medicaid expenditures  
13 as a result of that. I think it would warrant a  
14 look.

15

16 For example, with this most  
17 recent update in terms of increased deficit, a  
18 lot of it was blamed on eligibility on Medicaid.  
19 But I think those numbers basically were already  
20 assumed. So it's worth a look. Not a big to-do  
21 but it's worth a look and it may be prudent to do  
22 that.

23

24 If I can now take you  
25 sequentially into panel five, the story of health  
26 care is pretty dramatic. We've been on the  
27 chopping block for seven times since April of  
28 '07.

29

1  
2                   And I think, ladies and  
3 gentlemen - although I'm looking directly at all  
4 gentlemen at this point, but for the people in  
5 the audience - I think that the issue here is  
6 pretty clear.

7                   I can make the case that we have  
8 been whacked more than anybody else. But if there  
9 is somebody else, I'd like to know who they are.  
10 Because we have just gotten one hit after another  
11 hit after another hit.

12                   If you go -- and, of course,  
13 these are matters of history. We are looking at  
14 prospectively the eighth cut.

15                   If you go to the next panel  
16 after that, we just put up some numbers here of  
17 the effect of last year's budget on Medicaid  
18 spending per beneficiary. We compared that to  
19 welfare spending per case, K through 12, higher  
20 ed, corrections per prisoner, da-da-ta-ta-ta-ta.  
21 Take a look at those numbers. I mean this is  
22 where the chickens come home to roost in terms of  
23 what all these cuts have totalled.

24                   And I would not be telling any  
25 tales out of school that in our conversations

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with the Executive Branch, they do know that health care has taken more than its fair share of a cut. And I just point this out to you.

                  If I can now talk about - and I'm winding up, Mr. Chairman, so you don't -- I appreciate your patience, sir.

                  But if I could take you into panel seven. This is the FMAP money that came from Washington in a pie chart form.

                  The first part of the pie chart shows what health care represents of the total State budget. And, you know, it's a big number. We're about, out of the total spending, almost forty percent, thirty-nine percent to be precise, as this chart shows, of that number. And that is just the way the budget is.

                  When the FMAP money came in to the decisionmaking legislative process as well as Executive Branch processes, we found that, in terms of restoration of the cuts, you only used twenty percent of the money, twenty cents on a dollar, back into health care. The rest you did what you did with it.

                  And that's a matter of history

1  
2 too. So that's a sum cost. I can't get that back  
3 and it's gone. So I'm not going to beat a dead  
4 horse.

5 But the future is ours. All I  
6 ask is when FMAP money that has been pledged -  
7 and, as you know, at the U.S. congressional level  
8 and presidential level they are thinking about  
9 adding another six months to the FMAP money for  
10 the jobs program. It was part of the health care  
11 debate as well.

12 If that comes to be realized,  
13 then all I would say -- all I would say is that  
14 we should get our fair share of it. And I would  
15 ask you to do that.

16 Now, let's make a long story  
17 short in terms of what the pitch is here. Very  
18 simple.

19 If we can get the FMAP money,  
20 that will help reduce the targeted cuts on health  
21 care. How much? I don't know exactly, depending  
22 on how much is actually enacted. But it could be  
23 sizeable.

24 Get those numbers down,  
25 gentlemen, and then what we could do is we would

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like to work with you, work with the Legislature and work with the Executive Branch, in finding ways that those cuts can be absorbed in an orderly, systematic and mostly beneficial way to the people that we serve, and not do any harm.

And that's what I want to try to do.

I don't know if what I've said is possible, but I know the will, my heart is possible, and I want to do it with you.

And I'm not here to stiff arm you. I am here to be a colleague at this particular time.

That really winds up the presentation, Mr. Chairman.

I'd be more than happy to entertain any questions.

ASSEMBLYMAN FARRELL:  
Questions?

(No response.)

ASSEMBLYMAN FARRELL:  
Questions?

(No response.)

MR. KENNETH E. RASKE: Okay. I

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hope I was clear and not obnoxious.

ASSEMBLYMAN FARRELL: No, no.  
We heard you.

Daniel Sisto, President,  
Healthcare Association of New York State, HANYS.

MR. DANIEL SISTO: Thank you,  
Mr. Chairman.

On the assumption that a picture  
is worth a thousand words, our testimony isn't  
the usual narrative. It's just a set of pictures.

ASSEMBLYMAN FARRELL: Okay.

MR. DANIEL SISTO: And we'll  
put it up for those in the audience, but I think  
you have copies of it already.

ASSEMBLYMAN FARRELL: Yes, we  
do.

MR. DANIEL SISTO: The essence  
of my being here, I think, over the years has  
always been to tell you a story about what I  
thought was going to happen in the health care  
system.

And by a strange irony it was  
February 8th and 9th last year in meetings here  
where we had newspapers describing the situation

1  
2 in Queens. And the topics we were discussing at  
3 the time was what is going to happen, can we save  
4 St. John's, can we save Mary Immaculate. And the  
5 answer was we tried and failed, despite the  
6 Legislature's best efforts to intervene.

7 And this morning we start with  
8 can we save St. Vincent's.

9 The story has been the same  
10 actually year after year after year for about  
11 seven or eight years now because we've been  
12 locked in this spiral between dealing with  
13 deficits and trying to deal with expanded  
14 expenditures, not costs, but expenditures in  
15 Medicaid at the same time taking the simple  
16 solution, well, let's just keep cutting the  
17 providers. And that point was made I think pretty  
18 eloquently in your questions to the Commissioner.

19 Let me just move here to -- the  
20 point, a picture is worth a thousand words, the  
21 dramatic drop in 2008 in the bottomlines of these  
22 institutions, somewhat caused by the drop in the  
23 stock market and the bond markets. But they  
24 probably came back up half-way last year.

25 What's even scarier is not the

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dramatic line, but rather the operating line where we went from a plus \$800 million to a minus roughly \$500 million.

And that I think is the accumulation of cuts, the need to fund pensions that had also lost viability and so forth, but year after year after year essentially negative operating margins.

If the Federal reforms had gone through in Washington, we were looking at between \$12 and \$15 billion in reduced Medicare revenue to New York State providers. That would have been reduced by the number of people who got insured. However, the insurance piece, as you remember, was pushed out. So this is over ten years.

It didn't happen. Nevertheless, it's important as you go forward to keep in mind what's going on in Washington, which is that Medicare as a program is now cash flow negative. The Medicare Trust Fund will go insolvent in 2017 and the President and the Congress are pretty much committed to implementing the cuts anyway, only now without the insurance package, and they'll have to do it in a Federal budget.

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So the chart that I just showed you is likely to continue to simply get worse, and the story in New York, \$4 billion out of the providers in the last six State budget actions.

By the way, St. Vincent's isn't unique. It joins -- or potentially could join it's twenty-nine brethren and fifty-one nursing homes that have closed in the State during the time period that I've been talking about. That's the point of that particular chart, including probably some of your favorite old-time "requiescat in pace" as we used to say, "may they rest in peace." Fifty-one nursing homes along with them. And, of course, the jobs attendant to those institutions that we've lost.

Pretty much forty percent of the hospitals with wage freezes over the last -- this is last year.

A third scaling back capital projects, if they had them.

Almost everyone with hiring freezes.

And the irony, of course, that Medicaid enrollees and expenditures have gone up

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almost identically - there's the lines - rates of growth between 2000 and 2008.

Naturally, in the last year or so a lot of the increase in Medicaid has come -- as was noted earlier -- from the recession in the nation. And so we don't necessarily expect that line to get better very quickly, neither one of them.

But it's important for you, I'd ask you to remember as you go forward that expenditures in Medicaid are not the same as costs. And as Ken made the point, in fact, per capita costs have been flat or declining.

We now have twenty percent of New Yorkers roughly on Medicaid, Child Health Plus or Family Health Plus. And so one of the questions you can ask, answers when you ask yourself why are we so much higher than the national average, well, we start out with forty percent more people. And so when you divide that -- on Medicaid. So when you divide that by the population of the State, you know, we put ourselves behind the eight ball at the very outset.

1  
2 By the way, I happen to support  
3 the expansions that we've made. My point simply  
4 is you cannot continue to make promises without  
5 finding the ability to pay for them. And over the  
6 last ten years you've paid for them by cutting  
7 providers, the same people who are trying to  
8 deliver it.

9 And when that population goes  
10 up, we don't make money from that population over  
11 the last several years because, by and large,  
12 when people lose their Blue Cross or, you know,  
13 their private insurance, that pays, as the  
14 Commissioner said earlier, less money, not more  
15 money. We lose money when that transition occurs.

16 Medicaid beneficiaries: this is  
17 a very important slide because actually the  
18 4,000,000 people on the right hand side of that  
19 slide only drive about \$7 billion of the  
20 expenditures, whereas 400,000 on the other  
21 extreme are driving \$23 billion, and the ones in  
22 the middle, 450,000 drive \$9 billion.

23 So the point I'm trying to make  
24 here is, instead of year after year after year  
25 after year of cutting everyone across the board,

1  
2 what would happen if we truly made an across-the-  
3 board focus on the group in the middle and found  
4 a way to deal with chronic care management in a  
5 more effective manner.

6 This is just a -- it looks a  
7 little complicated. The point is the hospitals  
8 and the nursing homes are the two bottom lines  
9 that track along in terms of rates of growth.  
10 And, in fact, hospitals and nursing homes have,  
11 in fact, been cut and reduced and taxed to pay  
12 for the growth in every other aspect of the  
13 Medicaid program.

14 The Governor's budget would, in  
15 fact, of course, lose the Federal share and have  
16 implications on other payers when annualized.

17 We're talking about \$1 billion  
18 more being proposed to come out of the system.  
19 This is not counting, of course, the  
20 redistributions that will not go forward based on  
21 the 21-day amendments, because those weren't  
22 going to save any money anyway.

23 And we've gone around the State  
24 of New York, HANYS, because we represent  
25 hospitals really in every region, we literally

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2 told the hospitals outside New York City do not  
3 count on the money from medical education and bad  
4 debt charity care being redistributed. Take that  
5 out of the impacts because they're muting the  
6 damage that will be done to you and they make no  
7 sense frankly at a time of a physicians'  
8 shortage. And either the Governor will fix them  
9 or the Legislature will.

10

So now we're down to the nitty-  
11 gritty. And the nitty-gritty is there's still \$1  
12 billion in potential damage to be done through a  
13 whole variety of proposals.

14

And New York City, of course,  
15 taking \$344 million out of the \$500 million in  
16 those reductions. And probably, at least in my  
17 mind, the ones dealing with indigent care may  
18 tend to be the most odious, reducing all that  
19 money out of the pool.

20

We do support, as Ken has said a  
21 moment ago, dedicating the Federal Medicaid  
22 Assistance Program increased dollars to health  
23 care and for the reason he gave.

24

You'll see on the next one that  
25 we support the excise tax on the sugared

1  
2 beverages and tobacco. I heard your anxiety about  
3 that in the questions. I just want to share just  
4 one flipback to last year.

5           When that Federal money came in  
6 last year, I criticized the Governor because the  
7 very first thing he did was to use it to remove  
8 his own proposal on the tax on beverages and  
9 tobacco.

10           This year he has made it clear  
11 that if that money isn't there, we're in deeper  
12 trouble because he tied it directly to providers.

13           So I don't give you the public  
14 health speech the Commissioner gave you. I'm  
15 looking at it quite pragmatically. I don't know  
16 where the revenue comes from if we don't dedicate  
17 the FMAP money and we don't get that tobacco and  
18 sugared beverage hit.

19           I included, frankly, if there's  
20 going to be taxes, then I'm not in favor of the  
21 Insurance Department proposal. I would prefer,  
22 rather than have insurance companies go through  
23 the same regulatory system for approval that the  
24 malpractice companies have gone through that  
25 seems to have brought them to the brink of

1  
2 collapse, I would rather say, all right, we have  
3 for-profit insurers that took \$1.2 billion in  
4 dividends out of New York State this year, \$1.2  
5 billion - remember, we're hitting hospitals,  
6 nursing home and home care firms, a billion in  
7 losses, at the same time for-profit insurance  
8 companies are taking \$1.2 billion out in  
9 dividends.

10 So if we have to start  
11 stretching for taxes -- and if you can get away  
12 with it without doing so, fine -- other than  
13 FMAP, I don't know how we get away without doing  
14 it.

15 So we want the roughly \$1.1  
16 billion that should come to us in New York as a  
17 result of the President and Congress's  
18 discussions about extending it.

19 And as I said, the cut that I  
20 find remaining on the table to be the most  
21 problematic, I'd say odious actually, is to take  
22 \$187 million out of the indigent care pool at a  
23 time when hospitals are seeing more and more  
24 uninsured.

25 In fact, if you pick up today's

1  
2 New York Times, the business section, page one,  
3 column one, it is all about the impact of people  
4 losing their jobs, raising indigent care on  
5 institutions.

6 To take \$187 million out of that  
7 simply makes not a whole lot of sense to me,  
8 despite the fact that the Commissioner said his  
9 proposals of the administration would, in fact,  
10 preserve services to those in need and the safety  
11 net hospitals that serve them.

12 I think the record, as we look  
13 at that list of who closed and the St. Vincent's  
14 story this morning, and who's targeted for them,  
15 take a look at that list and see all the safety  
16 net institutions on that list about to lose money  
17 from a proposal to rip it out of the charity care  
18 pool.

19 And, of course, we're back on --  
20 you know, we're not going to do taxes except  
21 every year we're going to hit not-for-profit  
22 institutions for taxes.

23 So I think that absolutely has  
24 to be rejected.

25 The Governor is withdrawing the

1  
2 medical education proposal, but on preventive  
3 readmissions, which you asked the Commissioner  
4 about, I want to make sure that you're aware that  
5 it took months in Washington, bringing our  
6 medical directors from New York City and Upstate  
7 hospitals to meet with Pelosi and Reid staff to  
8 convince them, until the very end, that there's a  
9 distinction between preventable readmissions and  
10 those that are not preventable, between those  
11 that are planned and those that are unplanned.

12                   And just like when you spoke to  
13 Jim Sheehan about these raising the bar higher  
14 and higher targets, does that change behavior,  
15 without even knowing how much of this is genuine,  
16 we've already got a target of \$162 million for  
17 next year, \$50 million for this year, when, in  
18 fact, seventy to eighty percent of the people who  
19 are readmitted have substance abuse and mental  
20 health problems.

21                   So you can't dump everybody out  
22 of the institutions ten years ago and then  
23 complain if they get readmitted to hospitals is  
24 my point.

25                   I'll skip over some of these. I

1  
2 know the nursing home associations, NYAHSA and  
3 NYSHFA, are also going to testify.

4 But suffice it to say, we think  
5 we have to reject these nursing home and home  
6 care taxes, move forward on the rebasing and  
7 reject regional pricing.

8 We want to see malpractice  
9 reform, medical home models. I commend the  
10 Commissioner for the Adirondack, but we need a  
11 whole lot more incentive to move in that  
12 direction and facilitation of it via CON reforms.

13 We'd like to see transitional  
14 care units which to me are essential toward  
15 avoiding some of the readmission problems.

16 Clinical integration; and yet  
17 there's just the most modest nods of the head to  
18 it, what I consider to be real reform. Instead  
19 we're back with let's just cut everything across  
20 the board.

21 The Governor's proposed  
22 consolidating the Public Health and State Health  
23 Review and Planning Council, I don't have a whole  
24 lot of argument about that. But buried in that  
25 language is let's transfer full authority to the

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Commissioner to promulgate all reimbursement regulations, CON regulations, code regulations.

The reality is it's through those councils and their roles and somewhat the Legislature's direct role, where you have had oversight. And given the problems that I've talked about with the reforms, in quotes - I actually call them disruptions - I would say it is imprudent to invest in one individual that much authority and power, especially when we're dealing with all of this at the same time we're dealing with the effects of the recession, the Federal changes in the State budget.

What's at stake is the economy as well as the patient care we deliver.

I'll stop there.

Thank you.

Comments? Questions?

ASSEMBLYMAN FARRELL: Thank you very much.

MR. DANIEL SISTO: Thank you.

ASSEMBLYMAN FARRELL:  
Questions?

SENATOR HANNON: No.

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I just -- I agree with you on the SHRPC changes. No one had mentioned that. It acts as a counterpoint to the government just dictating. And it's not just the Commissioner. It's the entire government. And I think it's not a wise thing to do.

MR. DANIEL SISTO: Thank you.

ASSEMBLYMAN FARRELL: Jo Wiederhorn, CEO, Associated Medical Schools of New York State.

MS. JO WIEDERHORN: Good afternoon, Assemblymen, Senator, and Chairman Farrell.

I'm Jo Wiederhorn. I'm the CEO of the Associated Medical Schools of New York. We represent New York State's fifteen medical schools soon to be sixteen medical schools.

There are several important things about the budget that I would like to discuss today, but first I just want to give you an overview of a report that we are about to release in a few weeks.

The medical schools have commissioned an outside consulting firm to do an

1  
2 economic impact analysis of medical education,  
3 medical schools, academic health centers in the  
4 State.

5 In sum, let me just talk about a  
6 few of the key findings.

7 One, the total economic impact  
8 of New York's medical schools and primary  
9 hospital affiliates on the State equals more than  
10 \$85.6 billion. This is both direct and indirect  
11 economic impact.

12 Our member medical schools and  
13 our primary hospital affiliates support nearly  
14 7,000 full-time equivalent jobs in the State.

15 Collectively, the medical  
16 schools and the hospitals generate nearly \$4.2  
17 billion in taxes for the State of New York  
18 through income taxes, sales taxes, corporate net  
19 income taxes, capital stock franchise taxes and  
20 taxes produced by businesses receiving revenue  
21 from the schools and hospitals.

22 Our schools and hospitals  
23 generate over \$3.1 billion in medical tourism by  
24 attracting out-of-state patients, visitors and  
25 conference attendees and attract international

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dollars from outside of the U.S. in the areas of medical research and clinical expertise.

Our research efforts also generate funds for the State, approximately \$704 million on the economy, and for every dollar spent in research in the State, New York receives a return of \$7.50.

I think this is important in order to put in context the role that the medical schools play in the State's economy.

As a caveat to that, I just want to say that any cuts to hospital funding also impacts on the quality of medical education within the State. You cannot separate hospital funding from medical education. The two are intricately tied.

Some areas that I would like to discuss that I'm not sure will be discussed by other people testifying before you today.

The primary one is stem cell research. As you all know, the State has allocated funds for stem cell research making us one of the leaders in the country in terms of the research that is being done.

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2                   This year it's proposed that  
3           there will be approximately \$5.2 million cut from  
4           the \$50 million that's been allocated every year  
5           for ten years. This over the course of the whole  
6           allocation will result in almost a \$50 million  
7           cut in stem cell research.

8                   This is a really important piece  
9           of what makes New York's medical education a  
10          prime mover in the country. It is really vitally  
11          important to maintain these funds. Not only does  
12          it help in terms of the health and benefits to  
13          the citizens of the State, but it also is a  
14          revenue generator.

15                   As an example, Upstate Medical  
16          School just recruited a researcher from Miami who  
17          came here because he could continue his stem cell  
18          research funding. He brought with him additional  
19          NIH grants along with post-baccalaureate and  
20          other researchers from his lab.

21                   So these are definitely money-  
22          generating, revenue-generating sources in the  
23          State.

24                   We also would like to talk a  
25          little bit -- I also would like to talk a little

1  
2 bit about spinal cord injury research. These  
3 funds have been cut this year.

4           Actually, a little later I think  
5 that Mr. Paul Richter and Dr. Sally Temple will  
6 speak to this more eloquently than I can. But I  
7 just want to say that the funds to support this  
8 research, which is very important research, in  
9 terms of their -- it costs about \$1.35 million a  
10 year to support somebody who is a quadriplegic,  
11 and the intent of this research is to try to  
12 regenerate spinal cord injuries, spinal cord  
13 cells from injuries.

14           The important piece about this  
15 is that this money does not come from the General  
16 Fund. This money comes from surcharges that are  
17 placed on individuals and on insurance once  
18 people have been in automobile accidents.

19           Then -- next I would just like  
20 to talk a little bit about our post-baccalaureate  
21 program which the Executive Office and the  
22 Assembly and Senate have been so grateful to  
23 support over the last three years.

24           The intent of these programs is  
25 to ensure that there are underrepresented

1  
2 minorities who go into the field of medicine.  
3 We've had extreme success with these programs  
4 over the past few years. Eighty-five percent of  
5 the students who go into our program at Buffalo  
6 actually matriculate into medical school and  
7 eighty-five percent of those actually graduate.

8           These figures are important  
9 because these are students who otherwise would  
10 not have even gotten into medical school. So they  
11 are getting in and they are matriculating.

12           We also have a program at SUNY  
13 Upstate and a program at Stony Brook, and both of  
14 these programs also have very high success rates.

15           In addition, we support the  
16 Doctors Across New York Program. This is  
17 important in terms of the physician shortage,  
18 which Mr. Sisto mentioned just briefly. This is a  
19 program, the intent of which is to place  
20 physicians in underserved areas both rural and  
21 urban areas. It's -- actually the first cohort  
22 has started. It's a five-year program. If  
23 physicians agree to practice in underserved  
24 areas, they receive loan repayment for their  
25 medical school costs.

1  
2           The average student is coming  
3 out of medical school with a debt of over  
4 \$150,000, more like \$175,000 a year. So this is  
5 an important program. Funding was placed in the  
6 budget this year for a second cohort of  
7 individuals to be placed in this program and we  
8 support it wholeheartedly.

9           What we would like to do,  
10 though, is, according to the legislation as it  
11 was passed, a portion of this money was to go to  
12 hospitals and another portion was to go to  
13 medical schools. Because it has been in the past,  
14 although in the 21-day amendment this has been  
15 changed, but in the past it has been funded out  
16 of GME funds. Most of the money that went to the  
17 hospitals we are now asking for a small portion  
18 of this go to help residents and medical students  
19 learn about the program so that they would be  
20 more inclined to participate in it.

21           And then, finally, what I would  
22 like to talk about is medical malpractice reform.

23           This is a huge issue not only  
24 for the hospitals, but it is also a huge issue  
25 for the medical schools. Oftentimes the medical

1  
2 schools will pick up the cost of malpractice for  
3 physicians who are in their faculty practice  
4 plan.

5                   And you'll note that for an  
6 obstetrician in New York City malpractice  
7 coverage costs about \$210,000 a year, and for  
8 neurosurgeons it can be as high as \$230,000 a  
9 year.

10                   Our school -- Columbia  
11 University actually tells us that all of the  
12 obstetricians who are now practicing in northern  
13 Manhattan are actually faculty members at  
14 Columbia, otherwise they cannot afford to pay  
15 their malpractice insurance.

16                   So that we are hoping that the  
17 Legislature will do something about malpractice  
18 reform this year. Whether it be caps on awards or  
19 whether it be the bill that is now before the  
20 Legislature introduced by Senator Valesky and  
21 Assemblyperson McGee, which is the "I'm sorry," I  
22 call it the "I'm sorry" law where physicians can,  
23 in fact, say I'm sorry to patients and not have  
24 that become part of a suit, a lawsuit against  
25 them, or whether it be the formation of courts

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that are geared towards malpractice suits.

And that's all I have.

I want to thank you for your  
time.

Any questions?

ASSEMBLYMAN FARRELL: Thank you  
very much.

Questions?

(No response.)

ASSEMBLYMAN FARRELL: Thank  
you.

MS. JO WIEDERHORN: Thank you.

SENATOR HANNON: No.

But it's very important that you  
testify because our medical schools are one of  
the jewels of the whole State.

So thank you.

MS. JO WIEDERHORN: Thank you  
very much. I appreciate that.

ASSEMBLYMAN FARRELL: Dan Heim,  
Senior Vice President Public Policy, New York  
Association of Homes and Services for Aging.

Scott Amrhein, President,  
Continuing Care Leadership Coalition.

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Robert Murphy, Health Facilities  
Association, New York State, Executive Vice  
President Governor Affairs.

A VOICE: Mr. Chairman, I don't  
think that we are all together.

ASSEMBLYMAN FARRELL: I'm  
sorry.

A VOICE: We're not all  
testifying together.

ASSEMBLYMAN FARRELL: They have  
it here in the chart as -- okay.

A VOICE: I mean I have no  
problem with that.

ASSEMBLYMAN FARRELL: Well, no.  
If we could have them all together, because we  
are -- this is the 12:40 and it is 2:20.

A VOICE: It's all right with  
me.

ASSEMBLYMAN FARRELL: The  
question is are there chairs.

MR. DENNIS BOZZI: Mr.  
Chairman, my name is Dennis Bozzi. I'm the new  
State Exec for NYAHS. It's been here three  
months so I'm not used to your culture here.

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But please let us --

ASSEMBLYMAN FARRELL: That's fine. I've only been thirty-six years here.

MR. DENNIS BOZZI: I don't know what happened with the docket, but we have guests here that really are going to talk for us, two individuals who I think would be good for you to hear.

ASSEMBLYMAN FARRELL: All right. Let's go.

MR. DENNIS BOZZI: It's Ms. Sharee Danpere, President of Family Council at Beth Abraham, --

ASSEMBLYMAN FARRELL: Why don't you get yourself comfortable in the chair you are sitting in.

MR. DENNIS BOZZI: -- and Mr. Lee Kirby, a family member of one of the residents at Beth Abraham.

ASSEMBLYMAN FARRELL: And give me, again, your name.

MR. DENNIS BOZZI: My name is Dennis Bozzi, President of New York Association of Homes --

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ASSEMBLYMAN FARRELL: Now, I  
don't have you anyplace on this chart.

MR. DENNIS BOZZI: Oh!

ASSEMBLYMAN HAYES: You're the  
president of what?

MR. DENNIS BOZZI: The New York  
Association of -- NYAHS.

ASSEMBLYMAN HAYES: Instead of  
Dan Heim.

ASSEMBLYMAN FARRELL: Instead  
of Dan Heim?

MR. DENNIS BOZZI: Yes.

ASSEMBLYMAN FARRELL: Scott  
. Amrhein, is he around?

Okay. You're over there. And you  
belong over there. I don't know the guy next to  
you.

And Robert Murphy.

So you go.

MR. DENNIS BOZZI: Okay. Real  
brief.

What we're doing -- you heard  
all of it already so I'm not going to waste any  
of your time. We agree with a lot that has been

1

2       said already.

3

4                       But our strategy is to help you  
5       and to help us providers just to really get more  
6       engaged with the families of residents and  
7       residents themselves, to help chart the future.  
8       And we hope to have at least a thousand family  
9       members this year to help us in a family and  
10       friends network. And we just started. We have  
11       about three hundred and fifty families around the  
12       State that have residents or former residents in  
13       facilities that really are spirited to help us  
14       help you with the funding crisis.

14

                      So Sharee, do you want to start?

15

                      MS. SHAREE DANPERE: Dear

16

Legislative Body:

17

                      My name is Sharee Danpere. And  
18       I'm here today to appeal that you would support  
19       funding for health care, specifically as it  
20       relates to long-term care.

21

                      My mother, Grace Watson, was a  
22       resident at the Center for Nursing and  
23       Rehabilitation in Brooklyn, New York, for  
24       approximately two years until her death on March  
25       19, 2008.

1  
2                   The Center for Nursing and  
3 Rehabilitation is a 320-bed skilled nursing  
4 facility in the Prospect Heights section of  
5 Brooklyn. CNR has provided short-term and long-  
6 term care for at least thirty-two years.

7                   CNR provides vital services to  
8 patients and residents in New York City. Some of  
9 the services offered are adult day programs,  
10 Alzheimer's care, short-term rehabilitation,  
11 long-term care, caregiver support and the like.

12                   I am personally appealing that  
13 you give budgetary consideration to issues that  
14 will positively affect the Center for Nursing and  
15 Rehabilitation and other nursing homes.

16                   The State has cut health care  
17 seven times in the past three years, which has a  
18 direct impact on CNR. I fear that additional cuts  
19 may result in staff layoffs. This may drastically  
20 affect the level and quality of care currently  
21 provided to CNR patients and residents.

22                   Although my mother died almost  
23 two years ago, I am still an active participant  
24 in services at the Center for Nursing and  
25 Rehabilitation.

1  
2           The ongoing services that my  
3 mother received during the end of her life were  
4 vital to providing her with dignity and care. One  
5 year after my mother's death I was elected as the  
6 President of the CNR Family Council. My  
7 commitment to the goals of CNR is of personal and  
8 community-minded interest.

9           I want to thank you for this  
10 opportunity to speak on behalf of constituents  
11 who may not be able to speak for themselves.

12           Thank you.

13           ASSEMBLYMAN FARRELL:    Thank  
14 you.

15           MR. LEE KIRBY:    Hi!

16           My name is Lee Kirby.

17           My sister is a patient at Beth  
18 Abraham Hospital.

19           I want to talk quite briefly,  
20 turning the microscope around. We've been looking  
21 at the big picture. I want to start with the  
22 small and go to the big.

23           My sister has been with  
24 Parkinson's since she was fifty. She's now sixty-  
25 five, just turned sixty-five. It is a ravaging

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disease affecting, contrary to what most people think, the mind, the cognitive ability.

And she said to me one time as she was descending into kind of cognitive hell: Lee, the worst thing about Parkinson's is I'm losing my mind.

I said: Well, you're not crazy, but you just can't think.

When we decided to put her in a nursing home, which was absolutely necessary, she could no longer be maintained at home, I shopped around and looked at the obvious choices for Manhattan. I didn't like any of them. They felt like Marriott Hotels.

And I came to Beth Abraham and I felt like this is my place. And it has not failed me.

Why is Beth Abraham different? I think -- it's an old institution, but it has an incredible team work in the lowest levels of staff. The CNAs, the people who are most poorly paid, do wonderful work as a team.

And the perspective I would bring you from this is I'm told by the management

1

2 at Beth Abraham that the next level of cuts,  
3 we're going to be cutting the CNAs.

4

Now, on the affective side this  
5 -- you know, me as somebody who loves my sister,  
6 I hate the idea of her sitting around in a diaper  
7 and not getting it changed. That's what it  
8 amounts to.

9

That is insignificant to your  
10 real decisions because when a medical institution  
11 has that kind of team work at the lowest level,  
12 that team embodies the knowledge of the  
13 institution. Because health care is everyday  
14 stuff. And if we start leaching that team, I  
15 think it could have a profound and negative  
16 effect on the whole institution which has  
17 performed so well.

18

In addition, I've consulted with  
19 people in the hospital business and they say that  
20 is when you start getting opportunistic  
21 infections, that's when you get deaths because  
22 people didn't understand how to provide the care.

23

So it's a very worrisome moment.  
24 I beg you to make your cuts smart.

25

There is a lot to be said for

1  
2 keeping the people who are the least paid but do  
3 the most effective and knowledge-based work.

4 Thank you.

5 MR. DENNIS BOZZI: In  
6 conclusion, Mr. Chairman, I just want to say,  
7 being new to the State of New York, I've been  
8 here three months, it's been an amazing  
9 experience. I've seen such incredible providers,  
10 smart people, talented people all over the State,  
11 really working very hard. And I know you know  
12 that.

13 I'm just hoping that if we could  
14 curtail or use the FMAP appropriately and other  
15 ways to get predictable rates the next couple of  
16 years, I think we have to sit down and admit that  
17 the elderly care system in New York is broken.

18 It maybe is already dead, in  
19 fact. I'm not sure. And we have to sit down and  
20 look at new ways of designing it because it just  
21 isn't possible to continue this way.

22 Thank you.

23 ASSEMBLYMAN FARRELL: Thank you  
24 very much.

25 Questions?

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(No response.)

ASSEMBLYMAN FARRELL: Thank  
you.

Continuing Care Leadership  
Coalition, Scott Amrhein.

MR. SCOTT AMRHEIN: Good  
afternoon.

I'm Scott Amrhein, President of  
the Continuing Care Leadership Coalition.

I'm so happy that you've had a  
chance to hear from real families. You know, I  
think that it's fair to say that virtually every  
family in this State has one or more family  
members for whom there is no more important issue  
than these long-term care issues.

And for them, protecting health  
care is not a special interest. It is a public  
interest.

So I'm delighted that you had a  
chance to hear from them.

I'm now going to read my  
testimony. I'll abbreviate.

And the first thing I want to do  
is say thank you to all of you and to your

1  
2 colleagues. We have faced one of the most  
3 frightening sets of cuts during the deficit  
4 reduction plan era of October through November of  
5 last year.

6                   You heard our concerns and you  
7 really came through for the people like those you  
8 just heard from. So I thank you very, very much.

9                   Comparing what we're facing now  
10 to then, to the deficit reduction plan, I just  
11 want to stress the magnitude of these cuts.

12                   As bad as those proposed cuts  
13 would have been, these are worst. They exceed the  
14 DRP cuts for nursing homes by \$20 million. And  
15 the home and personal care cuts are forty percent  
16 greater than the cuts proposed in the DRP.

17                   If you think about these cuts in  
18 the context, you heard from Ken Raske about the  
19 seven rounds of cuts that we've already had. For  
20 nursing homes and home health care, that totaled  
21 more than \$1.2 billion and resulted in additional  
22 Medicaid losses of ten percent for nursing homes  
23 and three percent for home health care providers.

24                   And just think for a moment  
25 about what that has done to the fiscal health of

2 our long-term providers. They've driven nursing  
3 home finances to the brink literally, taking  
4 average operating margins from negative 2.1  
5 percent in 2007 to negative 11.3 percent in 2009.  
6 That is truly unsustainable.

7 They've also accelerated the  
8 rate of nursing home closures. This is really  
9 hard to imagine, but we are now seeing nursing  
10 homes in New York close at a rate of one closure  
11 every two months, and in New York City it seems  
12 like it's speeding up even faster now. It's  
13 really dire what's going on out there.

14 A couple of additional real  
15 consequences that we would urge you to think  
16 about.

17 If these cuts were to go  
18 through, the impact to Federal revenues to New  
19 York State would be substantial. Fully fifty  
20 percent of the nursing home cuts and seventy-  
21 seven percent of the home and personal care cuts  
22 would be accompanied by a loss of Federal  
23 matching payments. That loss would total about  
24 \$200 million in FMAP payments.

25 The impact on jobs we estimate

1  
2 would translate into a loss of 6,000 nursing home  
3 jobs and an additional 4,000 jobs in the home and  
4 personal care sector. You know, this would do  
5 irreparable damage to the quality of care  
6 available to Medicaid beneficiaries.

7           On page twelve of my testimony  
8 we begin to list a number of our specific  
9 recommendations. I will leave those for you to  
10 read, but I just want to highlight a couple.

11           The first is with regard to FMAP  
12 dollars that we hope will come to New York State.  
13 As you've heard, we really strongly encourage  
14 that you create a lock box to make sure that new  
15 FMAP relief is dedicated to the elimination of  
16 health care cuts and taxes on health care  
17 providers.

18           We support the elimination of  
19 the trend factor cuts and the new taxes on  
20 nursing homes and home health.

21           We support the elimination of  
22 the nursing home rate appeal cap and bed hold  
23 limitations.

24           And we're very concerned, as you  
25 heard from Dan Sisto, we share that concern about

2 regional pricing. And when we speak to you in  
3 communities and in private meetings, we've talked  
4 at length about our real concerns that the notion  
5 of reform that the State is moving towards has  
6 some really perverse incentives, and that we see  
7 the outcome of regional pricing being to undercut  
8 and to drive down quality in New York State.

9 We think this could be suspended  
10 with a charge to all of us to work to develop  
11 better long-range reform, and we are committed to  
12 do that.

13 But we think that, you know, if  
14 quality is the yardstick, this particular  
15 approach is not the way that we would want to see  
16 the State go.

17 The final thing I want to say is  
18 we have one more person who is a member of our  
19 Association speaking about some of the issues  
20 that affect specialty providers, like persons or  
21 organizations that serve individuals with HIV and  
22 AIDS.

23 Emma DeVito will be speaking  
24 later and she will do, I'm sure, a very good job  
25 of talking about the AIDS occupancy cut which we

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would like to see reversed.

So please do keep in the front of your mind the testimony of the family members that you heard. They is what it is all about.

We are pledged to work with you to come up with solutions to the problems that the State faces without undercutting and damaging vital health care.

So thank you very, very much.

I'll be happy to take any questions.

ASSEMBLYMAN FARRELL: Thank

you.

Questions?

(No response.)

SENATOR HANNON: No. But good.

ASSEMBLYMAN FARRELL: Thank you

very much.

Robert Murphy, Executive Vice President Government Affairs, New York State Health Facilities Association.

MR. MICHAEL SVENDSEN: Good

day.

My name is Michael Svendsen. I'm

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the Administrator of the Rome Nursing Home, an 80-bed facility in Central New York.

SENATOR HANNON: Speak into the mike.

ASSEMBLYMAN FARRELL: Can you use the mike?

MR. MICHAEL SVENDSEN: Joining me today is Robert Murphy, Executive Vice President of the New York State Health Facilities Association.

We estimate that statewide nursing homes and the benefits of New York nursing homes exceed \$6.34 billion in 2007.

Additionally, in the case of proprietary facilities, we are taxpayers and contribute about \$92 million to the coffers.

We've attached some statistical profiles for you to review and we will be brief in our remarks.

We would like to focus on the 2008 and 2009-'10 budgets as well as the deficit reduction budgets for the same period, concluding in 2010-'11.

To understand the precarious

1  
2 state in which nursing homes find themselves  
3 today, we must first visit the very recent past.  
4 It is important to understand two things.

5 First, 75.8 percent of nursing  
6 home patients in New York are Medicaid supported.  
7 12.1 percent are Medicare supported. When you add  
8 in the veterans and the Medicaid managed care,  
9 close to ninety percent of all of the patients  
10 that we serve are government supported.

11 Secondly, over seventy percent  
12 of nursing home expenditures are for labor. We  
13 are a very hands-on profession and that's our  
14 most expensive commodity.

15 Since 2008 and '09, nursing home  
16 rates have been cut four separate times for a  
17 rate reduction of \$562 million.

18 In your chart you can see the  
19 rundown from April \$16 million, August \$265  
20 million, January of 2009 \$152 million, and in  
21 April \$127 million.

22 Make no mistake about it. These  
23 cuts have taken their toll. And between 2001 and  
24 2009, fifty-five nursing homes have closed.

25 Add in the 2010-'11 budget, the

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budget cuts of \$562 million just since 2008 and '09, and now the Governor proposes additional assessment and cuts of \$251 million, for a total of \$814 million in our industry in just the past three years.

These cuts have sadly been unsustainable as evidenced by closure of facilities and clearly there will be coming more facilities closing in the days to come.

We've also included in your briefing some of the Governor proposals for this year.

The trend factor for inflation saves the State \$46 million, and our cut is \$110 million for the industry.

With no other increases, the trend factor is the only way we have to provide our staff with an increase this year.

Also, you'll see some enactments for one percent non-reimbursed gross receipts revenue tax which generates \$67 million for the State and \$87 million in cuts to our industry.

However, again, this represents a significant reduction in the climbing amount of

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money that we've had to pay.

There's other amendments in there for:

A reduction on bed hold;  
Capping facility rate appeals,  
that I'll leave you to read;

Reductions for certain drugs that we would support;

And one for the proposal to increase the TC units from five to ten sites. We do not believe this is really a budget issue. And, secondly, our Association has opposed the proposal since it inappropriately creates a system whereby patients are kept in a hospital who should be served better in a nursing home at a lower cost in a more appropriate setting.

Again, we would like to mention the budget proposed recommendation for the consolidation of membership of the State Hospital Review and Planning Review and the Public Health Council.

There are many unanswered questions that need to be considered. Until they are, a fair assessment cannot be made.

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And then, briefly, on the Federal level, the Federal government has also retrenched on its payments to nursing homes.

A CMS rule reduced nursing home reimbursement this year by \$360 million, which will impact nursing homes another \$66 million.

Additionally, a House bill will reduce our Medicare reimbursement over ten years by \$23.9 billion and \$1.4 billion to New York. The Senate version slashes \$14 billion, which is \$918 million for New York.

MR. ROBERT MURPHY: Before we close, Michael did a very nice job of summarizing all the points.

Just a couple of points from today.

I'd be a little bit disingenuous if I didn't acknowledge this year's budget appears to have from the Division of the Budget and the Department of Health a little more of a provider friendly take to it.

What do I mean by that?

I obviously oppose new taxes and I obviously oppose certainly the elimination of

1  
2 the trend factor. But I will acknowledge that the  
3 tax that's proposed saves us from the cut we  
4 would get if you did a rate cut by losing the  
5 Federal dollars. And it would be unfair of me if  
6 I didn't acknowledge that that, indeed, the  
7 dollar-for-dollar impact of a tax on us as  
8 opposed to a cut, which is also the Federal  
9 share, is much less injurious than the other.

10 The other piece that's in here,  
11 and certainly I obviously don't agree with  
12 capping the rate appeals. There does seem to be a  
13 willingness on the part of the Department and  
14 probably the Governor's Office to discuss the  
15 issue of rate appeals and how we might  
16 consolidate and negotiate on it. If, indeed,  
17 that's what it is what I read, I would like to  
18 acknowledge that that's a step forward in the  
19 process of trying to solve this major backlog.

20 I would be remiss also if I  
21 didn't comment that the warm and fuzzy feeling  
22 that the Office of Medicaid Inspector General was  
23 giving you is not being enjoyed on a facility  
24 level I'm sorry to report.

25 We have significant issues with

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the way that OMIG is coming into facilities. And make no mistake about it. We're not talking about issues of fraud here. We fully agree when you go after them for fraud. We're talking about recordkeeping issues. We're talking about failure to document something as simple as a physician's signature. We're talking about when every knowing person here would say the services were delivered, you just forgot to cross that "t" and dot that "i." They're going after hundreds of millions of dollars. It's a real problem.

It's double jeopardy. They are doing audits on things we've already been audited. It's a whole new set of rules that they're making up on their own.

For instance, I will tell you when the Health Department comes into a facility and finds a facility owes them, because of the unique nature of the nursing home business - Michael talked about it - ninety percent of our dollars are government dollars, seventy-five percent are Medicaid, the Department of Health will not recoup any more than fifteen percent of the check. OMIG is telling us they want a hundred

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percent of the check.

Make no mistake about it. When we're seventy-five percent Medicaid, a hundred percent of the check means we will not meet payroll. It's as simple as that.

There's no acknowledgement of these kinds of things.

So I would love to think it was a world of understanding and we're all just going to get along on this thing. But they're a lot of questions that have got to be answered.

There was a reference by Senator Johnson. We have developed legislation which we will be sharing briefly with all the Legislature. And we would ask your help in having at least a set of rules that people are allowed to understand.

So I wanted to say that the last thing I would say, and I appreciate your time, is I join the other groups in saying this time when we get FMAP money, it shouldn't just go for the reduction of the budget deficit.

FMAP money from Washington was intended the first time to take away the need for

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provider cuts. It was a direct -- one of the direct purposes of that aid.

If the FMAP comes again, which we supported along with all the other associations, we'll do it again to get the money into New York, we would just hope that this time there's a reasonable consideration given to employing it against the cuts that have been proposed to you.

MR. MICHAEL SVENDSEN: With that, are there questions that anybody would have?

ASSEMBLYMAN FARRELL:  
Questions?

(No response.)

ASSEMBLYMAN FARRELL: Thank you.

Next, we're going to have a panel of four people, unless there's a conflict:

Self-Help Community Services,  
Valerie Bogart, Director of Legal Research  
Program;

Consumer Directed Personal  
Assistance Association of New York State, Barbara

1  
2 Zimmons, Executive Director;

3 Consumer Directed Personal  
4 Assistance Program, Chris Layo, Consumer;  
5 Concepts of Independent Choices,  
6 Tony Caputo.

7 MS. CONSTANCE LAYMON: Hi! We  
8 have a little bit of a change.

9 My name is Constance Laymon. I'm  
10 the President of the Consumer Directed Personal  
11 Assistant Association of New York State.

12 ASSEMBLYMAN FARRELL: What is  
13 your last name?

14 MS. CONSTANCE LAYMON: Laymon,  
15 L-a-y-m-o-n.

16 First, we do have to start with  
17 a very big, big thank you to the Executive  
18 because one of our biggest issues is now off the  
19 table, the 21-day amendments. And that was this  
20 personal care cap regarding the consumer directed  
21 personal assistance program.

22 Unfortunately, the cap itself  
23 does remain, and having sat through some of the  
24 testimony today and hearing some of the comments,  
25 there are a lot of serious issues that still

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prevail to apply this, you know, cap even though it's considered to be more of a soft cap because you're not saying, okay, twelve hours is it, that people will just shift into other programs.

The problem is that those other programs will not work for these consumers.

There is the managed long-term care program, the long-term care waiver, the nursing home transition and diversion waiver. These programs will not be able to provide the high needs that these consumers have. These are medically necessary needs.

There are already regulations in place. They're called 50514 under Title 18 that specifically say under this State plan that these medically necessary tasks will be provided.

The problem with using these other models, you heard the testimony earlier. Mark Kissinger sat right here. They're hoping for a reduction in hours. They're hoping for people to choose less.

But the problem with that is is that people need to be able to live independently. They need to be able to be safe

1  
2 and get the services that they need for their  
3 disabilities.

4 We have Chris who receives  
5 twenty-four hour care. He can speak directly to  
6 the fact that he's not overutilizing. This isn't  
7 some kind of, you know, chess game, you know, on  
8 a board of life.

9 The prepared testimony that we  
10 had done is very much moot in many ways because  
11 of the consumer direction off the table. But when  
12 we're sitting here as a culture paying billions  
13 of dollars in bailout money to banks, to private  
14 corporations, and then we, people with  
15 disabilities and seniors, are expected to bear  
16 the brunt in rising Medicaid costs because now  
17 we're out of money, what is wrong with us as a  
18 culture? This doesn't make any sense.

19 So I'm going to turn this over  
20 to Chris who can put an actual face. You don't  
21 choose this issue, and the fact that twenty-four  
22 hour care or -- let's put it this way. Anything  
23 above twelve hours isn't something that needs to  
24 be managed. These are medically necessary  
25 situations that aren't going to change by, you

1  
2 know, case managers coming in and fiddling with  
3 things. These are disabilities.

4 MR. CHRIS LAYO: The testimony  
5 that I wrote today was -- it's no longer on the  
6 table because the CDPAP program was now taken off  
7 of the Governor's proposal.

8 So basically all I can say is  
9 that I'm in a consumer directed program and I  
10 know what it is like every day to do this.

11 And I'd just like to basically  
12 be in it because I'm -- it gives me independence  
13 and it allows me to feel like a normal American.  
14 I don't feel like I'm in a medically -- like  
15 because I'm in my own home. It's not a medical  
16 feeling. I don't feel like I'm in a facility or  
17 put into an institution or something like that.

18 I'm just happy that I can be on  
19 my own in my own home.

20 Thank you.

21 MR. ANTHONY CAPUTO: My name is  
22 Anthony Caputo. I'm the CEO of Concepts of  
23 Independence and Concepts of Independent Choices,  
24 two affiliated non-profits.

25 Again, I came here with

1  
2 testimony to indicate that we oppose the  
3 Governor's plan to reduce hours and to eliminate  
4 any Medicaid authorizations greater than twelve  
5 hours a day.

6 This morning we were fortunate  
7 to hear for our program, the Consumer Directed  
8 Personal Assistance Program, that that now is off  
9 the table.

10 I was prepared to go into  
11 details on how cost effective we are, but I  
12 understand that it's still on the table for  
13 possible cuts to the personal care program.

14 I can only say that our program  
15 is extremely cost effective, the consumer  
16 directed program. In New York City I know we do  
17 have a tremendous number of cases, over a hundred  
18 and fifty cases that do receive more than twelve-  
19 hour-a-day care. Specifically, they're getting  
20 twenty-four hour day care. These are individuals  
21 on life support, ventilator dependent, trachs,  
22 individuals that must receive twenty-four hour  
23 care.

24 And I do want to thank the  
25 Executive Branch for not cutting that program.

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2                   These are individuals that, if  
3 left alone even for a few moments, if there was a  
4 fire, if there was anything in the home, these  
5 people would be left to die. They are unable to  
6 hit a call button or a monitoring button or  
7 anything.

8                   So I do want to thank the  
9 Executive Branch for that.

10                   I just want to broadly say and  
11 quickly that the consumer directed program along  
12 with the personal care program we feel is very  
13 cost effective. It is quite efficient. I know  
14 it's quite large in the New York City area. I  
15 know the City program operates at around \$16.95,  
16 around \$17.00 an hour. But I think you'll get  
17 your own -- you'll get testimony by others, New  
18 York City vendors on that.

19                   Our program is even more cost  
20 effective. We are doing the consumer directed  
21 program at about \$16.17 an hour. We pay the  
22 workers the same as though they are in the  
23 personal care program. These workers are not only  
24 doing personal care tasks, but because of the  
25 exemption to the nurse practice act in the

1  
2 consumer directed program, these workers are able  
3 under the supervision of their consumer, they are  
4 able to do nursing tasks, suctioning, feeding  
5 tubes, Medicaid administration and so forth.

6 So our program is extremely cost  
7 effective.

8 We also provide our workers an  
9 array of health insurance benefits. We have  
10 almost three thousand workers in our  
11 organization. They get family coverage for those  
12 that stay beyond twelve months at an extremely  
13 low cost. It's \$10 for single coverage and \$25  
14 per payroll biweekly for family coverage.

15 And that also, if we quantify  
16 the numbers, that are keeping those individuals  
17 and their families off other government-sponsored  
18 health care programs.

19 So I think we get a real bang  
20 for the buck in our program. And I think it's a  
21 win/win situation which allows consumers with  
22 high skilled nursing needs to remain in the  
23 community, to go to shows, go to plays. Many of  
24 them work. Many of them pay their own spend-down.  
25 So, therefore, that Medicaid doesn't pay one

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hundred percent of their home care costs. And our program enables that rather than institutionalization.

So we thank the Executive Branch for taking the CDPAP program off the table and the limitation of the hours.

And if there are any questions, we're here to answer them.

ASSEMBLYMAN FARRELL: Thank you.

Senator.

SENATOR DeFRANCISCO: You're from St. Lawrence County?

MR. ANTHONY CAPUTO: Yes.

SENATOR DeFRANCISCO: You're from St. Lawrence County and you are able under the current rules to obtain twenty-four hour a day care; correct?

MR. ANTHONY CAPUTO: Correct.

SENATOR DeFRANCISCO: Okay. You were here during the testimony when I was asking questions about the personal care allocation dollars between New York City and Upstate; correct?

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MR. ANTHONY CAPUTO: Yes.

SENATOR DeFRANCISCO: Despite the fact -- it's obvious that you're provided what you're needed, that Upstate is doing right by you, and I believe right by other people who have necessities in determining what the proper amount of care would be. If it wasn't the case, I'd be hearing about it and many other legislators up north.

The purpose of my questions was that it is totally unfair, and no doubt those people that need twenty-four hour a day care in New York City, it is totally unfair for half of the population to cost more than, probably more than four times what it costs upstate.

And the purpose of my questions, I hope you understood them, was that New York City, whatever their model is, isn't working as effectively as upstate, and they should be saving dollars by following the upstate models rather than creating a situation where the Governor has to find places to cut services that maybe people from upstate are using.

Did that come out clear? I just

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want to make sure of that.

MR. ANTHONY CAPUTO: Yes.

SENATOR DeFRANCISCO: Okay. All right.

Secondly, you're from New York City?

MR. ANTHONY CAPUTO: Yes.

Can you tell me why it costs so much more in New York City than upstate to provide the same services?

MR. ANTHONY CAPUTO: Well, are you talking in dollars or costs per hour? Because, first of all, I only can discuss --

SENATOR DeFRANCISCO: Why are the people in New York City that are receiving care, Medicaid care, care paid for by Medicaid, personal care, why do they receive more than twice the number of hours than the average person outside of New York City?

MR. ANTHONY CAPUTO: Okay.

I can only speak for Concepts of Independence.

We're the consumer directed program. We serve about 1300 consumers out of the

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I believe approximately 50,000 that are being cared for in New York City.

Our program was founded by individuals with severe disabilities, quadriplegics. In 1980, when the program was becoming vendorized in New York City and throughout the whole City, our group of family members, we're all quadriplegics, all had required twenty-four hour care.

But I can only speak for our 1300 out of the 50,000.

SENATOR DeFRANCISCO: Who is the gatekeeper in New York City?

MR. ANTHONY CAPUTO: The Human Resources Administration. They are a part of the City of New York. They are the Department of Social Services in the City.

SENATOR DeFRANCISCO: Okay.

And do you know - maybe you don't know - but do you know if the gatekeeper's rules in New York City are different than the gatekeeper's rules upstate? Do you know?

MS. CONSTANCE LAYMON: Well, I can just answer that a little bit in that I'm

1  
2 also an appointed member to the work group that  
3 the Legislature established last year to look at  
4 the certified home health agency reimbursement.

5 And there has been a lot of  
6 fingerpointing at upstate versus downstate in the  
7 certified home health realm and now in the  
8 personal care realm.

9 And I guess -- again, I was here  
10 for the testimony earlier with the Department of  
11 Health. And one thing that we've been bringing up  
12 at the work group is that the Department of  
13 Health has oversight over districts, whether it  
14 be local counties or HRA.

15 And right now the personal care  
16 program is a State plan service. And under the  
17 State plan there are those regulations I just  
18 cited where the medical necessity piece is  
19 listed.

20 So how they actually do it is  
21 something that is under the purview of it. So if  
22 the Department of Health actually went in with  
23 the oversight functions that they have to look at  
24 who may or may not be overutilizing or not in the  
25 way that they should, that we wouldn't be perhaps

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here saying why are we looking at this across the board.

I know people in New York City who need 24/7 and are not.

SENATOR DeFRANCISCO: And no doubt there is.

But the utilization is substantially greater in the City. And I just want to be fair. And if there is money to save there by emulating the model upstate, it should be done.

MS. CONSTANCE LAYMON: Right.

SENATOR DeFRANCISCO: The other -- on the other point, the advocates for self-directed care in my area have from time to time have told me that if a consumer - anybody can answer this - if a consumer is allowed the flexibility of self-directed care, they can save money in the system because there are many cookie cutter services that the consumer might not want, might not need and can say no to and also get the services that they really need and the number of hours they need.

Does anybody want to comment on

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that?

And if you have any examples,  
that would be wonderful.

MS. CONSTANCE LAYMON: And we  
met with you with Sally Johnston --

SENATOR DeFRANCISCO: Okay.

MS. CONSTANCE LAYMON: --  
exactly.

Well, consumer directed personal  
assistance is a different mold from the medical  
model which is traditional home care.

Within consumer directed you  
don't have the same nursing levels, aide levels.  
You have this level where the consumer manages  
their recruitment, hiring, training, supervision  
and termination. By them managing that, Medicaid  
doesn't expend that money. When a self-directing  
person does that, an agency doesn't have to do  
that. That saves money.

But also the simple fact that  
the nursing piece, as Tony had mentioned earlier,  
with that amendment to the nurse practice act --  
when I was with the visiting nurses before the  
consumer directed program existed, when a nurse

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had to come do certain nursing tasks, it was \$90 per nursing visit as opposed to \$17 under the consumer directed program. You can't replicate that anywhere.

And I'm happy because I get to do it when I want, how I want it done. It's just amazing.

SENATOR DeFRANCISCO: Thank you very much.

ASSEMBLYMAN FARRELL: Thank you  
Further questions?

(No response.)

ASSEMBLYMAN FARRELL: Thank  
you.

SENATOR HANNON: Mr. Chairman,  
let me add.

ASSEMBLYMAN FARRELL: Yes.

SENATOR HANNON: You did very  
well by getting the Governor to change his mind.

And you also did well by coming here and showing Senator DeFrancisco that there is a different part of the population, which is yourselves. And since we put this program in about ten years ago, you've really shown why

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finetuning Medicaid can really work for the individuals and for the system.

MS. CONSTANCE LAYMON: Well, just quickly.

Last budget this was a whole big discussion about expanding this program.

There was a \$500,000 appropriation. Fortunately, that RFA didn't come out and proposals due till January, a couple of weeks ago.

So here we are -- and thankfully everybody backed off. But it wasn't that long ago we were expanding this and now --

SENATOR HANNON: You need to change the name of the program from personal assistance. It sounds like some luxury instead of being essential.

MS. CONSTANCE LAYMON: Right.

SENATOR HANNON: And people keep going into budget, they don't have a background, they don't know what it is, and they say, oh.

MS. CONSTANCE LAYMON: Well, good point.

SENATOR DeFRANCISCO: And also

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if you could let us know how you changed the Governor's mind because we've got a few things that we want to change.

MS. CONSTANCE LAYMON: Well, it's a secret weapon.

SENATOR DeFRANCISCO: It was a facetious question. You don't have to answer it.

MS. CONSTANCE LAYMON: Secret weapon called Bruce darling.

MR. ANTHONY CAPUTO: I don't want to say it on the record so I'll tell you later.

But we do want to thank the Governor for that.

MS. CONSTANCE LAYMON: Yes.

ASSEMBLYMAN FARRELL: Thank you.

Elie Ward, Director of Policy and Advocacy, American Academy of Pediatrics;  
Gerard Conway, Esq., Senior Vice President, Government Affairs, Medical Society of the State of New York;

Deborah Elliott, Deputy CEO, New York State Nurses Association;

1  
2 Chris Kjolhede - I'm in trouble -  
3 Chairman, Coalition for School Based Health  
4 Centers;

5 Kate Breslin, Director of  
6 Policy, Community Health Care Association of New  
7 York State; and

8 Tracey Brooks, President and  
9 CEO, Family Planning Advocates of New York State.

10 MS. ELIE WARD: And I think  
11 we're all surprised that we're talking together.

12 I'm Elie Ward. And I think at  
13 this hour we can all be extremely brief.

14 What I would like to do is --  
15 first of all, that was a very hard act to follow.  
16 So I would honestly say that I'm here  
17 representing the 6,000 pediatricians across the  
18 State who take care of about 4.5 million  
19 children. The other 300,000 children are taken  
20 care of by family physicians.

21 So I'm here to talk about the  
22 needs of kids in the health care budget.

23 But I also am here to let you  
24 know that the well-being of children is a core  
25 concern of all pediatricians because children

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2 can't thrive on good medical care alone. They do  
3 not exist in isolation. Their well-being is  
4 dependent on the strength of their families, the  
5 quality of their day care and their schools,  
6 their access to healthy food and clean water, the  
7 safety of their environment and the availability  
8 of recreational, socialization and learning  
9 opportunities in their communities.

10 We understand that this is  
11 really a tough budget year, but we also  
12 understand that you have critical choices to  
13 make, and some of those choices have to do with  
14 revenue.

15 I will announce absolutely and  
16 firmly that we are very much in favor of the  
17 sugared soda, sugared drink tax.

18 Whatever one may think about  
19 imposing additional taxes at this time, the  
20 science is the science on this. And soda and  
21 sugary drinks are the biggest contributor to  
22 childhood obesity. And it's our people that see  
23 those kids, kids who before they are teenagers  
24 have diabetes, have high blood pressure, have  
25 heart problems, things we've never seen before,

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2 the first generation of children who probably  
3 will have a shorter life expectancy than their  
4 own parents. It's not a pretty picture.

5 And I don't think that we can  
6 say that we don't do this because we can't do it  
7 all. Yeah, candy is not good and other things  
8 aren't good. But you have to start somewhere.

9 And the idea of doing what's  
10 possible and at the same time being able to stave  
11 off some additional cuts to health care makes  
12 perfect sense to us.

13 You got all the statistics from  
14 the Commissioner so I'm not going to go through  
15 that.

16 I can only say that what we find  
17 most compelling is that whenever we are talking  
18 about how much it costs, it really is \$8 billion  
19 in obesity-related health care. And each family  
20 is already spending over \$700, which they see in  
21 an increase in insurance premiums, an increase in  
22 co-pays, an increase across the system.

23 So if we can even reduce a  
24 percentage of obesity and reduce the hidden costs  
25 that families are paying, everyone comes out

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2 ahead in the end and the kids certainly come out  
3 ahead because the impacts of obesity early in  
4 life are very significant going forward and have  
5 the potential, as some research has shown, to  
6 really be catastrophic to an already teetering  
7 health care system.

8           The fear of job losses we think  
9 is a red herring because these are very big  
10 bottlers and they can certainly produce other  
11 products like water and diet soda, which we don't  
12 propose to be healthy but it is an option for  
13 them.

14           We also think that sometimes  
15 state leaders have to lead. They can't always  
16 follow what's popular. They have to take a stand.

17           And in this instance I would  
18 say, again, only because we believe in the  
19 science, the science says this is the right  
20 public health thing to do.

21           I'm old enough along with some  
22 of you to remember the outcry when tobacco was  
23 being taxed and taxed and taxed, and people were  
24 saying don't do this to us. And, you know -- I'm  
25 a former smoker. I remember feeling a little put-

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upon at the time.

But we learned that it was better not to smoke. We also learned that it takes a long time to change people's habits. There are still people that smoke even though we've done an amazing job at public education. There will always be people who do unhealthy things. The idea is to get that number reduced so that fewer people are unhealthy.

We also, obviously, strongly support taxes on tobacco. And, you know, which hasn't been spoken about much, we would also support additional taxes on alcoholic beverages. And it's not because we're teetotalers. We just think, especially for kids, the more expensive we make alcoholic beverages, the more impact that it might have on some of the binge drinking that goes on, and it's something that is worth looking at.

I also talk about some of the incredible costs involved in many of these activities and their costs across a lot different systems. Alcoholism and substance abuse have a huge cost in domestic violence and in our

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criminal justice system. And they also cost families.

And I think it's time for us to just sort of say we'll tax what's bad for us, we will use the money for health, we will do public education, we will do what we need to do to help kids and families be healthier. They can't do it on their own.

The other issue I want to bring up, which is very specific to kids, is the early intervention program for infants and toddlers.

And I would just say that we completely oppose parent fees in this program. I just want to be really clear about that.

But we do support getting insurers to pay for these costs. What we would like to see is this program have more pediatric involvement so true medical necessity can be determined and then insurers should pay for that medical necessity.

My big issue is, I will be very positive about the primary care investments, as I'm sure some of my other colleagues will be. And what we would like to see is, going to some of

1  
2 the things that were said this morning, is a  
3 model for kids called Bright Futures New York.  
4 And this is a model that would create a true  
5 medical home for children across all the systems,  
6 both the public system, the subsidized system and  
7 commercial insurance.

8 We are working with some  
9 legislators now on this and we would like to also  
10 work with the Administration a little bit. We  
11 have worked with the Department of Health.

12 We think there are two ways to  
13 demonstrate the quality and the efficacy of a  
14 medical home.

15 One is going through the  
16 integrated system which the Department is doing  
17 now.

18 But also another part is looking  
19 at the needs of special populations. And, you  
20 know, children are not small adults. They have  
21 very special health care needs.

22 So you can read about Bright  
23 Futures. It's here. Obviously I've done several  
24 papers on it which you've seen over the years.  
25 Some of you know it very well.

1  
2 We think this is the year to do  
3 it. We think an investment in Bright Futures this  
4 year is really part of what primary care should  
5 be.

6 We also are very, very  
7 supportive of Doctors Across New York and we're  
8 also supportive of driving primary care dollars  
9 into primary care practices, whether they're  
10 multiple practices, clinic practices or hospital-  
11 based clinics. The money has to be driven where  
12 it can - to go back to something that was  
13 discussed before - truly keep people out of  
14 emergency rooms and keep them out of hospitals.

15 And the only way we're going to  
16 do it is shift the way we reimburse care.

17 We obviously support  
18 streamlining and the ongoing support for Child  
19 Health Plus and Children's Medicaid program, and  
20 obviously medical homes.

21 And I'll tell you that one of  
22 the things we feel very, very strongly is that  
23 the Department should take rate-setting abilities  
24 back in the health insurance area.

25 And we also support the proposed

1  
2 physician gift ban, just so you know. We spoke to  
3 our principals and they feel very strongly that  
4 doctors don't need to get gifts from  
5 pharmaceutical companies or medical device  
6 makers. And what they need is easily accessible  
7 and objective information on new drugs and new  
8 devices that improve the health outcome of their  
9 patients. And how doctors get this information  
10 can and should be structured in a way that  
11 precludes the appearance of undue influence.

12 Our only suggestion, which is in  
13 here, would be that the first time somebody walks  
14 over the line, they don't get smacked with a  
15 really big fee, then that there be some really  
16 focused education. If we're going to change the  
17 rules, we have to let everybody know that the  
18 rules have changed and when the rules have  
19 changed.

20 Again, looking at the cuts, we  
21 think that some of these cuts across the board,  
22 not just in health, are penny wise and pound  
23 foolish, and that actual dollars saved by some of  
24 the program cuts are really small.

25 So we would encourage you, in

1  
2 closing, to look carefully at what you do. And,  
3 as I've said year after year when we've had bad  
4 budget years, make your cuts with a scalpel and  
5 not a sledgehammer.

6 And to my right --

7 MR. GERARD CONWAY: Right.

8 Thank you, Elie.

9 I'm Gerry Conway with the  
10 Medical Society. We will be submitting our  
11 testimony obviously and not reading it today.

12 Just to highlight what's in it,  
13 we do touch on the beverage and cigarette taxes  
14 and we agree with Elie on that. We think that  
15 those are important from a public health  
16 standpoint, let alone the revenues involved, that  
17 we don't approach it from the revenue-raising  
18 standard, we approach it from public health. And  
19 the connections and linkages are so obvious that  
20 it doesn't bear any discussion at all.

21 We also appreciate the primary  
22 care initiatives that are put forward in there.  
23 We support them. We think they are long overdue  
24 and that they are essential to a restructuring of  
25 the system or reorientation of the system that

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makes it more affordable as our population ages and as costs rise.

I agree also with a couple of our earlier speakers, Dan Sisto, Ken Raske, Jo Wiederhorn, all talked about medical liability reform, the need to address medical liability within the context of the budget.

We think that goes without saying. Health care obviously is a huge part of our budget and medical liability costs, direct and indirect, are a huge part of health care cost. So we think that you cannot seriously address the cost issues involved in health care without looking at medical liability. It should be included, all aspects of it: quality initiatives, insurance changes and also the civil justice system. All of them have to be examined and examined objectively to see the extent to which we can achieve sometimes competing objectives fairly.

But we must recognize that we cannot simply ignore medical liability when we address the State budget.

Managed care is hugely important

1  
2 to us. I want to just say - it's in our testimony  
3 obviously, but we support the prior approval and  
4 the medical loss ratio. We think it's essential  
5 that they go together. You can't have one and not  
6 the other or they're subject to abuse.

7 We also support the surcharge  
8 provided the surcharge that is in the Governor's  
9 proposal is cast in such a way that the intended  
10 payers, the companies, the insurers, are not  
11 allowed to effectively redirect it to reduce  
12 provider compensation or reduce consumer/patient  
13 benefits, or enhanced fees for businesses or the  
14 public, the State, in terms of the cost of  
15 insurance. But managed care has got to be  
16 remedied.

17 I woke up this morning and the  
18 morning shows were on and I saw what's in The Los  
19 Angeles Times, what - I'm sure all of you have  
20 probably seen or maybe you haven't because you've  
21 been busier than I have. I obviously was lounging  
22 around with a cup of coffee watching the morning  
23 shows.

24 But the President of the United  
25 States has done something almost unprecedented in