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

JOINT LEGISLATIVE HEARING

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

Hearing Room B
Legislative Office Building
Albany, New York

February 3, 2020
11:09 a.m.

PRESIDING:

Senator Liz Krueger
Chair, Senate Finance Committee

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

PRESENT:

Senator James L. Seward
Senate Finance Committee (RM)

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

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

Assemblywoman Aileen Gunther
Chair, Assembly Committee on Mental Health

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PRESENT: (Continued)

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

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

Assemblywoman Ellen Jaffee

Senator Luis R. Sepulveda

Assemblyman Michael Cusick

Senator George M. Borrello

Assemblywoman Kimberly Jean-Pierre

Senator Diane J. Savino

Assemblyman Angelo Santabarbara

Senator John Liu

Assemblywoman Melissa Miller

Senator Gustavo Rivera

Senator Anna Kaplan

Assemblywoman Patricia Fahy

Senator Fred Akshar

Assemblywoman Nathalia Fernandez

Assemblyman Charles D. Fall

Assemblywoman Mary Beth Walsh

Senator Sue Serino

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PRESENT: (Continued)

Assemblywoman Marianne Buttenschon

Senator Elizabeth O'C. Little

Assemblyman David I. Weprin

Assemblywoman Carmen N. De La Rosa

Senator Robert Jackson

Assemblyman William Colton

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CHAIRWOMAN KRUEGER: Good morning. My name is Liz Krueger. I am the chair of the New York State Senate Finance Committee and cochair of today's budget hearing.

Today is the fifth of 13 hearings conducted by the joint fiscal committees of the Legislature regarding the Governor's proposed budget for state fiscal year 2020-2021. These hearings are conducted pursuant to the New York State Constitution and Legislative Law.

Today the Senate Finance Committee and the Assembly Ways and Means Committee will hear testimony concerning the Governor's proposed budget for the Office of Mental Health, Office for People With Developmental Disabilities, Office of Alcoholism and Substance Abuse Services, and the Justice Center for the Protection of People With Special Needs.

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

I will now introduce members of the

Senate, and afterwards Helene Weinstein will introduce members of the Assembly.

So for the Senate Democrats, we have Senator David Carlucci, Senator Pete Harckham, Senator John Liu, Senator Luis Sepulveda, Senator Diane Savino, Senator Anna Kaplan and Senator Gustavo Rivera.

And for my Senate Republicans, James Seward is the ranker on Finance.

SENATOR SEWARD: Thank you, Madam Chair. I'm pleased to introduce, from my conference, Senator Fred Akshar and Senator George Borrello.

CHAIRWOMAN KRUEGER: Thank you. Assembly.

CHAIRWOMAN WEINSTEIN: We have with us Aileen Gunther, chair of our Mental Hygiene Committee, Assemblyman Cusick, and Assemblywoman Jaffee.

And now our ranker, Assemblyman Ra, will introduce members of his conference.

ASSEMBLYMAN RA: Thank you.

We're joined by Assemblywoman Missy Miller, our ranking member on the Mental

Hygiene Committee, as well as Assemblywoman Mary Beth Walsh.

CHAIRWOMAN KRUEGER: Great. All right. So after the final question-and-answer period of the relevant government representatives, there will be an opportunity for members of the public to briefly express their views on the proposed budget under discussion.

Just some of the rules of the road here. We discourage protests that interrupt the flow of the hearing. If you like something you're hearing and you want to do this (gesturing), that's fine. If you don't like it, you're of course welcome to testify or let us know in lots of ways, preferably not interrupting the flow of the hearing.

Please pay especially close attention to the time clocks if you are one of the people testifying. Government representatives have 10 minutes to present; members of the public will have five minutes to present. For both, please don't imagine you're going to read your full testimony. If

you're showing up with more than two pages of testimony, you won't get through it. So you want to think about bullet-pointing the critical issues that you want to make sure we know about.

We are all getting copies of everyone's testimony. The testimony is going up online for anyone to pull up and read and review. This hearing is being live-streamed. There's lots of opportunities for you to participate even if you're not here with us today.

Chairpersons of the relevant committees have a 10-minute allotment for questions and answers of governmental witnesses; all other legislators who are members of the relevant committees receive just five minutes.

And except for the relevant chairs, there will be no second round of questioning. Relevant chairs can have a five-minute second round if they need it.

Any legislator who feels the need to ask additional follow-up questions but

doesn't have a second round, please present them to either Helene Weinstein, my cochair, or me, and at our discretion we may ask those questions of the witnesses.

For nongovernmental witnesses, all legislators only have three minutes to ask the witnesses.

I think I've covered sort of the rules of the road. Oh, one more thing. Please when you're testifying speak carefully into the microphone as close as you can to your mouth. We do not have an ideal system. And also for those of us who are up here on the daises, if you're not speaking into your mic, please turn it off. Because you don't know that the mic is hot and everyone listening in on their computers somewhere outside of this room is hearing everything every one of us says.

So if you don't really want to share that information, make sure your mic is off, because you won't realize what's happening, but people text in and call in saying, "That was so interesting, Liz," "Why were you

saying that, Helene?" So let's be very careful.

On that note, I would like to invite up Commissioner Sullivan, from the Office of Mental Health.

COMMISSIONER SULLIVAN: Good morning. I'm Dr. Ann Sullivan, commissioner of the New York State Office of Mental Health.

Chairs Krueger, Weinstein, Carlucci, Gunther and members of the respective committees, I want to thank you for the invitation to address OMH's 2020-2021 proposed budget.

I would like to thank the Legislature for your continued support of reinvestment funding, which emphasizes providing care in community-based settings. Since 2014, with a commitment of more than $100 million in annualized investments to date, OMH has been able to provide services to more than 70,000 new individuals, bringing the total to over 800,000 people served in the public mental health system.

Examples of the new community services

that have been funded are supported housing units, child and adolescent crisis/respite beds, clinic program expansion, additional OnTrackNY teams, crisis intervention teams, assertive community treatment or ACT teams, and long-stay transition support teams.

Because these community services are available, New Yorkers can get the support they need to avoid hospitalization, access inpatient services only when needed, and live successfully in their communities.

Building on these investments, the 2020-'21 Executive Budget recommends significant investments for the OMH not-for-profit workforce. These investments include resources to leverage over $40 million in new annual funding to provide targeted compensation increases to direct care, support and clinical staff, and to support provider costs for minimum wage increases.

The Executive Budget increases support for OMH housing initiatives by an additional $20 million for existing residential

programs. Since 2015, OMH support for these programs will have increased by $70 million. Additionally, the budget includes $60 million in capital to maintain and preserve community-based residences. The budget provides an additional $12.5 million for certain individuals living in transitional adult homes in New York City who wish to transition to more integrated settings in the community.

The comprehensive parity reform enacted last year will enhance state oversight of insurers and require them to apply the same treatment and financial rules to behavioral health services that are used for medical and surgical benefits. Importantly, this new law authorizes OMH to review and approve medical necessity criteria used by plans.

Additionally, the creation of the Behavioral Health Ombudsman program, otherwise called CHAMP, Community Health Access to Addiction and Mental Health Care, and the enactment of the Mental Health

Substance Use Disorder Parity Reporting Act have assisted individuals and their families in accessing behavioral health services. CHAMP has handled 1,600 cases while providing education to an additional 5,000 individuals, family members, caregivers, or providers.

In October 2015, New York State was one of 23 states awarded a one-year planning grant and an implementation grant two years later from the federal government to create Certified Community Behavioral Health Clinics. CCBHCs improve health outcomes through increasing access to care; reducing avoidable hospital use; and providing behavioral health care entities in underserved areas with more financial stability; and integrating mental health, substance use, and physical health services. OMH's experience has been increased access to enhanced behavioral health services and decreased need for acute care for both mental and physical health.

School-based mental health clinics are another area where New York State continues

to increase access to treatment by providing services on-site. Currently there are 806 school-based mental health clinics in New York State. Three years ago, there were less than 300 such clinics.

Suicide prevention continues to be a priority issue. OMH has partnered with state agencies and communities to implement recommendations from the Governor's Suicide Prevention Task Force. The Task Force also identified gaps in suicide prevention efforts and made recommendations to identify at-risk populations where increased engagement efforts are needed, including Latina youth, the LGBTQ community, black youth, veterans, and individuals living in rural communities.

The FY 2021 Executive Budget includes a plan to transform the Kingsboro PC campus into a recovery hub facility, focused on shortening lengths of stay and providing centralized community support services, including a step-down transition to a community residence program. This transition is consistent with OMH's patient-centered

approach to care with an emphasis on recovery.

Finally, OMH's goal is to increase access to prevention and community services, intervening prior to the need for more intensive and costlier care. For those who continue to need inpatient hospitalization, New York State has the highest number of psychiatric inpatient beds per capita of any large state in the nation, and we will continue to preserve access to inpatient care as we transform the system.

Again, thank you for this opportunity to report on our efforts to support and continue the work that we have jointly embarked upon to transform New York's mental health system.

Thank you.

CHAIRWOMAN KRUEGER: Thank you.

First up, Senator David Carlucci.

SENATOR CARLUCCI: Thank you, Madam Chair.

And thank you, Commissioner Sullivan. Thank you for your commitment to our

community and protecting some of our most vulnerable populations.

As you know, we've spoken at length about many of the issues that you're working on. I wanted to start off with our commitment to our workforce. And, you know, we've shared conversations about how important it is that we invest in our workforce, that we encourage the longevity of our staff, and that we make sure that we don't have this transition that we are consistently having to retrain and also we're providing a lack of service to the individuals we serve if we have that transition consistently.

You know, last year we had a victory in including a 2 percent wage increase across the board for our human service workers. We find now we're hearing from service providers, they tell us that that wage increase has not yet been released. It was supposed to go out January 1st.

Do you know anything about that? Can you tell us about that?

COMMISSIONER SULLIVAN: Well, as far as I know, it's set to be released as soon as possible. So I don't know the exact date, I can't say that to you. But I can get you that information afterwards.

But I -- there is another 2 percent increase in this year's budget as well, which will be 2 percent and then 4 percent for direct care workers in April, and another 2 percent for clinical care workers.

So these increases are very real. I know that sometimes there might be a delay, but they are very real and they will happen.

SENATOR CARLUCCI: Okay, thank you.

And just to get into some of the nuances of the budget, we've worked together on suicide prevention; my colleagues in the Senate, we passed a bunch of different pieces of legislation to try to tackle the increases that we've seen in suicide rates across the board.

And one, I want to thank you for the recent report that was put out from OMH on suicide prevention. We passed the

legislation on the black youth suicide. And I know you've been working with Dr. Lindsey on how we integrate and make sure that we're working specifically in that area.

Would you be able to give us any information on what's going on with that, what you plan to do and what we can see in this year in terms of outreach to the black youth community and across the board on suicide prevention?

COMMISSIONER SULLIVAN: For sure, yes. And first of all, I want to thank the legislative members for their interest and for their commitment to suicide prevention. I think everyone who speaks to this helps to decrease the stigma and helps to bring to everyone's attention the importance.

On the black youth suicide, we have had conversations with Dr. Lindsey, who is the national expert in this area. It's a very tragic fact that young black youth, ages -- as early as 10 years old, there's been a significant increase in suicide.

They published, through his work, a

report from the national caucus, the Congressional Black Caucus, which outlines a whole series of steps to work on how to address this issue. Those steps include things like research -- it's one of the things he's looking for. Other things, though, include working with communities, working with faith-based organizations, and doing a great deal of intervention in schools.

And what we're going to be doing with Dr. Lindsey is targeting the particular areas. We have -- through our databases, we can pick out particular hotspots where there have been a number of suicide attempts or particular problems within certain communities, and we'll be doing that in the black youth community. We'll be working with the schools in those areas, the faith-based organizations, parents, outreach campaigns to increase the community's awareness and understanding of the problem.

And we're doing a similar effort with other groups as well. It's going to be a

similar approach with Latina youth. We have Dr. Silva from Rochester who's assisting us with that. And we're doing it with rural issues. There's a high incidence of suicide in rural communities. And we're going to be doing it for veterans, law enforcement, and for LGBTQ communities.

So in addition to the overall suicide approach, which is general public awareness, which includes a lot of training in schools -- over 25,000 trainings last year, individuals who were trained -- we are also targeting specific high-risk communities, and we will be doing that in conjunction with the various community agencies that work with those groups, with the counties, with everyone else, to ensure that we get the word out. It's a multifactorial problem, suicide.

And the other area -- not to take too much time, the other area we're working very intensely with is the provider, both on the health side and on the mental health side. So for example, there's an initiative now in 90 emergency rooms across the state to do

better follow-up after suicide in the --

SENATOR CARLUCCI: I'm sorry, 90 what?

COMMISSIONER SULLIVAN: Emergency rooms, medical emergency rooms across the state, to do improved follow-up and treatment of individuals who come in post-suicide attempt.

SENATOR CARLUCCI: Could you touch on -- we were really excited to see, in the Executive Budget, a million dollars dedicated to suicide prevention for veterans and first responders, law enforcement. We've seen a spike, unfortunately, in law enforcement suicide rates. Could you tell us about how that money will be utilized?

COMMISSIONER SULLIVAN: Yeah, we're in the process of planning that. You know, I think that -- first of all, it's very exciting to have the dollars for a campaign for suicide prevention anti-stigma. But we're going to be working very closely with the law enforcement agencies and the first responders. They know best how to work with the individuals in their forces. So we're

working with the State Police, with the New York City PD, and we're working with all of the veterans organization, the state veterans organizations, the Office of Victim Services, interagency.

And I think within -- probably within six to eight weeks we'll have a plan that we'll be able to come out with. But we really need the input of those -- they're groups, groups that have worked with those individuals. When you work with law enforcement, it's very important that individuals who work with them understand the issues of law enforcement. And so we're also going to be doing some training of staff so that individuals will be available for services. That's one of the issues, to have enough individuals who understand the issues of law enforcement and first responders in treating individuals who may need treatment in order to prevent suicide.

SENATOR CARLUCCI: Okay, thank you. And we have been working extensively on eating disorder issues and knowing that if we

put the right policies in place, we can help a lot of people and diagnose them early to get the treatment that they need.

And I know there's been a move for a transfer of the Comprehensive Center for Eating Disorders from the Department of Health to the Office of Mental Health. Could you briefly tell us about that and tell us -- you know, we're really looking for the reassurance that that program will continue and not be at jeopardy now being under the auspice of the Office of Mental Health.

Can you tell us, has the money come with it from the Department of Health? What safeguards will be in place to make sure that that not only continues but expands?

COMMISSIONER SULLIVAN: I think, first of all, it's a great need and there's a commitment on the part of the Office of Mental Health to ensure that it continues.

In terms of the dollars, the $118,000 that was in the Executive Budget is coming with it. The other million dollars which traditionally has supported these eating

disorder specialty centers, and there are three across the state, has been a legislative add in each year. So that -- to the Department of Health, which is a different agency than the office of OMH.

So there are discussions going on right now about that additional add, which has been there over time to support these centers. They're very important. They really are the places -- the three places -- I think it's Rochester; it's the city, at Columbia; and it's in the Albany area -- where people go for the expert help that they can need for the major eating disorders.

They also do a lot of outreach for the general population in terms of obesity and other issues. So there is a great commitment to continue these. There is the question of the money, which will be discussed, I think, over the budget negotiations.

SENATOR CARLUCCI: Yeah, it's something I'm very concerned about, because there is that million-dollar reduction and now it's coming from the Department of Health

to OMH. So that's something we're going to have to work closely on. I'm hopeful that possibly the Governor, in his 30-day amendments, will include that million dollars in the OMH budget to make sure that this doesn't fall off the table.

There's so much we need to talk about, but I know our time is limited. We talk about, in your opening statement, the transition from adult homes to supportive housing. There's money in there for New York City. How about the rest of the state? As well as the Governor said in his State of the State the commitment towards supportive housing. Where can we point to in the budget that shows us where those dollars are to build the supportive housing that we need?

COMMISSIONER SULLIVAN: Yeah, the -- throughout the -- there are points in the budget, I think it's a total of $12.5 million which is going for the adult home in the city.

There are an additional 1200 units in the budget, not including those 500, that are

going to be opening up as part of the pipeline for the rest of the state. Those will be distributed across the state. And basically that includes a combination of funding from the ESHI, the Empire State -- it includes some funding from the old New York/New York III housing. So throughout the budget there are line items which talk to the amount of dollars that are there.

But it will -- and maybe I misspoke for a minute. I think the 500 are in there. So I think it's a commitment of 1200 including the 500, I don't -- yes, including the 500 adult home slots. But the other 700 will be distributed across the state in various areas. Which is what we have traditionally done with all the housing that has come up. Basically we look at areas where it's needed, we get developers who hopefully can put up the housing.

Also last year we had an additional 250 slots for homeless, a number of those slots for apartments. A number of those were upstate -- in fact, a good number of them

were also upstate.

So we try to distribute as best we can the housing across the state, and it's all kind of lined-itemed out in the budget under the housing sections, so ...

SENATOR CARLUCCI: As far as OMH, how many housing units do you believe we will have?

COMMISSIONER SULLIVAN: There will be 1200 new ones this year. There were approximately 1200 last year for OMH. That includes the adult homes and additional housing through ESSHI and New York/New York III.

So the total number of housing units in the state now is 47,000, which is really great. It probably -- not probably, is the largest commitment to supportive housing in the country for the seriously mentally ill.

SENATOR CARLUCCI: I see I'm out of time. Thank you, Commissioner.

COMMISSIONER SULLIVAN: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Assembly.

CHAIRWOMAN WEINSTEIN: Thank you.

We've been joined by Assemblywoman Fahy, Assemblyman Santabarbara, and Assemblywoman Fernandez.

And we now go to our Mental Health chair, Assemblywoman Gunther.

CHAIRWOMAN KRUEGER: And as she's about to speak, I also forgot to introduce Senator Sue Serino and Senator Akshar, who both joined us.

ASSEMBLYWOMAN GUNTHER: Thank you for joining us today, Commissioner.

I wanted to start off regarding the funding crisis for our mental health providers. Last year we were able to increase for direct support professionals; however, the increase was still below the rate of inflation, and mental health clinicians only received 2 percent beginning April 1st.

As you know, this year the mental health and developmental disability community is united around a 3 percent increase over five years. We have been seeing raises in

other sectors of healthcare. We are losing our workers in this system left and right, as you well know. We know that the turnover in the DSP community is tremendous.

And, you know, as a nurse myself, Ann, we realize that these DSPs, they create relationships with their patients and their loss is a loss to the patient.

My question to you, then, is what can we do to impress upon the second floor that these raises are desperately needed.

COMMISSIONER SULLIVAN: The budget does include a 2 percent increase for direct care workers as of January, and another 2 percent in April, and also in April for clinical care workers. And that's similar to what it was last year, and there was an agreement that that would be in the budget this year.

I think that's about $25 million to the Office of Mental Health, including the minimum wage increases. And basically, it does help significantly, I think, to support in some ways. There's always a question of

whether more is needed, but I do think this is a significant contribution to the workforce on the mental health side. And when you add in the -- it's $40 million when you add in the contributions from the federal share and the annualization of the dollars.

So that's very real, it's in the budget, and it will happen this year. It's been about -- over five years, about a 14 percent increase for direct care workers.

ASSEMBLYWOMAN GUNTHER: Well, I think it's much needed. But I would say that most of the workforce are women. And honestly, to have an apartment, it's really not a living wage. I live in an area where the delivery of care to people with disabilities, most of our employees are connected with those kinds of jobs, mostly women. You know, we have an issue with daycare. And also to get an apartment, feed your children, it's just not a living wage. It's just not.

And we've lagged behind for years and years before. We're doing some catch-up, but we really have to do more, Ann. I know that

you're on the same page, but I'm hoping that the second floor will take a look at it and -- rather than -- this is economic development, making sure that these doors stay open. So rather than invest in new economic development, keep what we have. So my piece.

A recent study by the Council of School Superintendents showed that more than two-thirds of school superintendents report that improving mental health services is their top priority.

I know OMH has done a good job of expanding satellite offices in schools, but I'm wondering why the Executive would decline to continue the enhanced rates for children -- children's behavioral health providers.

COMMISSIONER SULLIVAN: The enhanced rate -- the rates were set, and there were start-up rates initially -- for six months, 25 percent, then going down to 12.5 percent. And it was always known that basically those start-up rates would end. And the start-up-rate date for the start-up rates to

end was January 1st. So yes, those start-up rates have been discontinued, the increase.

However, the long-term commitment to the expansion, which is considerable -- because it's important to remember that these services were designed to expand services to youth. And basically before the legislation and before this change in services, youth had to be -- they had to kind of almost fail first to get these services.

So basically the redesign has enabled youth and families to get the services sooner and for more to get those services. So the end result after these services are up and running, over time, is an expectation that there will be a considerable increase in services for kids and a considerable amount of money spent on those services.

So that has not changed. That commitment is still there, even though the start-up dollars, yes, have been discontinued as of January 1st.

ASSEMBLYWOMAN GUNTHER: Thank you.

According to the United States

Interagency Council on Homelessness, New York State has more than 90,000 people experiencing homelessness. That's roughly 3 times that of Florida, a state that has about 2 million more people than us.

Granted, not every person who is homeless has mental illness, but we know many do. Most aren't logging onto the OMH website or calling the field offices to look for service. How can we better reach these folks?

COMMISSIONER SULLIVAN: Well, we've been doing a lot of outreach in terms of -- just for New York City, as an example, there's --

ASSEMBLYWOMAN GUNTHER: So explain -- so there's two things I want to know. Explain what we mean by what outreach, and how we're doing it, number one. And New York City is one area --

COMMISSIONER SULLIVAN: Absolutely.

ASSEMBLYWOMAN GUNTHER: -- but we're looking at low-income areas in the middle of the state and other areas. So we're not just

going to be tunnel vision on New York City.

COMMISSIONER SULLIVAN: No. No. Absolutely. I'm sorry to say that. So I'm not -- I'm not --

ASSEMBLYWOMAN GUNTHER: I know, but I just have to say that, because a lot of times we talk about New York City.

COMMISSIONER SULLIVAN: No, I appreciate that.

No, the issue here is that there's various -- well, it's a -- absolutely, homelessness is a complicated issue. For the seriously mentally ill, the group that often people see and have a lot of questions about, are the individuals who are on the streets. And they are in the streets in many ways, and homeless, not in great situations, throughout the state, not just in New York City.

But there's a number of things that we have done. One is the homeless outreach teams, through county aid to many of the counties as well as the city. That county aid goes to homeless outreach teams. What's a homeless outreach team? These are

individuals who go out to work with the seriously mentally ill on the streets to help them try to accept services. And for a variety of reasons -- to some extent it's sometimes the way they see the world, it's sometimes the way they want to live. It's very difficult to engage some of these individuals.

So we do spend a fair amount -- it's almost $10 million, $12 million across the state, to work on these outreach teams which we fund through county aid. And we monitor that.

The second area is working in the various shelter systems. To the extent that they can be safe havens is one way -- one name that we have for some of these. And we do a lot of that work as well.

We also have ACT teams that we have funded to work with the homeless, and they help the homeless transition from these safe haven shelters into apartments and give them the kind of wraparound supports that they need.

So that's when you've found someone who's already homeless and on the streets. But the bigger piece of this is not to get people homeless and on the streets and to help provide the services that prevent that from happening. And that we've been working very diligently with a whole series of crisis stabilization centers, crisis services, increasing intensive outpatient services, working with increased diligence on discharge planning when people leave the hospitals, so they don't get to the point where they've decided in some level that their home is on the streets.

So there's a number of things that have to happen: The preservices, to make sure that people don't become homeless; and then if they do, especially if they have trouble accepting services -- and the biggest part of helping people accept services is trust and engagement and connection. And that takes time. And that's why we fund these outreach teams that get to know the individuals who live on the streets and

really work intensively with them.

ASSEMBLYWOMAN GUNTHER: How is the $12 million distributed?

COMMISSIONER SULLIVAN: I think it's about 9 million to the city, and then there's another series of dollars which go to the counties. I could get you the exact dollars for that.

ASSEMBLYWOMAN GUNTHER: So there's 9 million to New York City.

COMMISSIONER SULLIVAN: Mm-hmm.

ASSEMBLYWOMAN GUNTHER: But that's half the population of New York State. And the other half of the population gets 3 million? If it's 12 million, that's my calculation.

COMMISSIONER SULLIVAN: Well, approximately -- I can get you approximately what it is through county aid. It depends on the counties and how it's distributed.

But again, there's outreach teams and then there are housing. And the other big piece that we have distributed across the state in housing -- and upstate gets

approximately half of the increases in the housing that we do in terms of some of the stipends, et cetera. That prevents the homelessness as well.

So the housing -- and it also depends on the number of street people in each particular county. So it can vary from county to county, depending upon the number of people on the streets.

But the housing is distributed across the state, and that's pretty much distributed by population base in the various counties.

ASSEMBLYWOMAN GUNTHER: We are spending a tremendous amount of money in upstate New York housing our homeless in hotel rooms for big dollars, so much more than if they had stabilized housing. And also their health isn't good, mental health isn't good.

And so to me, if we could look at that in terms of money saving and healthier people -- because right now I represent Sullivan and Orange County. Most of my homeless population are in less than

adequate, horrible hotels. Because when someone is considered homeless, they have this idea in their head that they're like bad people. So certain hotels won't take those folks or for that rate that the county gives them.

So I think we could do a lot better and a lot more if we really provided more stabilized housing, not only in New York City, but in upstate New York you have Buffalo, you have Syracuse, and we have it all. You know, we all share part of that population.

CHAIRWOMAN WEINSTEIN: Thank you.

We've been joined by Assemblyman Fall.

Senate now?

CHAIRWOMAN KRUEGER: Thank you.

Senator Pete Harckham.

SENATOR HARCKHAM: Thank you, Madam Chair.

Commissioner, good to see you, as always. Thank you.

I just have one question for you. In my work as chair of Alcoholism and Substance

Abuse -- and with colleagues up here, we just toured the state focused on the opioid crisis. And so much of -- and the science now ties it with co-occurring disorders, the nexus of mental health with substance use disorder, the notion of self-medication.

And I know you and OASAS have been working closely on the blended license, which is a step -- a big step in the right direction. But one of the things that we've heard from people, both providers and from patients all across the state, is there are still obstacles with billing and paying. That they can now go to one treatment center, but they are still treated differently in terms of the billing stream. So there's seeing a peer for substance use disorder is one bill, seeing a mental health counselor is another bill, seeing a psychologist is one bill, seeing a CASAC is another.

We're still not addressing the blended person with holistic treatment and really one bill. Where are we with that? What needs to be done? How close are we? And are there

things that the legislative body can do to be helpful?

COMMISSIONER SULLIVAN: You know, I think -- you know, we're definitely looking at that. Now, I think -- I believe that the community behavioral health centers that we've established are easier in that respect than some of our other Article 31 providers in terms of the ease with which the billing occurs for the client, for them to experience it.

And I think that's the model that we would like to try to use to expand to the other sites. I think that in some of the sites it's gotten a bit better. But yes, we have to work -- it's a combination of working with commercial insurers and depending upon what their desires are, then working with managed care through Medicaid. Sometimes it is difficult to get all the bills straight. We work a lot with the providers about that.

So you're right. And we should be working to make sure that that's kind of seamless for the client. I realize that's

where we get into trouble here, so the clients get bills.

So we will continue to work on that. But the CCBHCs seem to have been able to do this in a more seamless way than some of the others, and we're going to try to use that model to help some of the other centers as well.

But yes, there can be difficulties sometimes with getting all the bills organized from multiple providers and insurers.

SENATOR HARCKHAM: Great, thank you.

Thank you, Madam Chair.

CHAIRWOMAN KRUEGER: Thank you.

Assembly.

CHAIRWOMAN WEINSTEIN: We go to Assemblywoman Miller.

ASSEMBLYWOMAN MILLER: Good morning.

So I pride myself on being the voice for those who have the quietest voices. A few of the questions that I'm asking have come directly from those voices, people who live in my district or surrounding districts

who have serious concerns and have asked me to share.

On Long Island this past week there was a ceremony for the opening of a mental health clinic in Rockville Centre. It's a collaboration between Cohen Medical Center and five local school districts. The clinic will provide emergency mental health services, like acutely that day, until a healthcare provider can be located for long-term services. It's needed, and it sounds great.

What we're not acknowledging is that this is necessary because there's a shortage of healthcare professionals who have availability in the first place to see these patients. Because most mental health professionals, at least on Long Island, don't accept insurance, the few that do are completely booked. It would be very difficult to find a mental health provider that takes insurance that could fit in a new patient immediately and provide the availability that's needed more than once a

week when first treating a patient for a person in crisis.

Hospital emergency rooms evaluate pediatric patients with mental health issues to see if they're a danger to themselves or others and, if not, they get referred to long-term-service providers, who can't take them.

The clinics, which are collaborations between Cohen and school districts, are needed because there's no place for these pediatric patients with mental health issues to get the immediate attention by medical professionals. But this collaboration is costing each of these school districts $55,000.

We all know that our school district budgets cannot sustain this, and they shouldn't have to. There are school districts that are in financial distress. Is it fair that the districts that can squeeze it out of their budget will have that and the school districts that can't afford it shouldn't?

Schools should not have to spend $55,000 annually to a hospital for immediate access to mental health professionals for its students. It should be done automatically via our insurance providers or Medicaid.

So what can we do about this continuous problem that currently exists where the majority of mental health professionals don't accept insurance? There are months-long waiting periods to get an initial appointment, and they don't accept insurance or Medicaid. If you're lucky enough to have a plan that does allow out-of-network coverage, maybe you can get a percentage of that visit reimbursed. It's a very real obstacle to seeking and receiving treatment.

I can tell you that I've experienced this firsthand myself with both my daughter, who experiences anxiety, and my mom, who has Alzheimer's. When my daughter began having panic attacks, we could not find a psychiatrist who could see her for three months. We finally wound up taking her to a

crisis center, who prescribed a medication that made her feel worse and recommended therapists for long term, who also didn't accept insurance and had waitlists.

For my mother, I'm desperately trying for several months now to find a psychiatrist. My mother, who was herself a clinical psychologist, is very depressed and frustrated by not being able to remember anything and losing her independence. I can't even tell you how many doctors I have called. I've had conversations with these psychiatrists who acknowledge the problem, and they can't schedule an appointment for another two to four months.

When I asked what to do if she's having trouble now, I was told to bring her to a crisis center.

We are forcing people into crisis by not having the mechanisms in place to help them before they're in crisis. How do we not see that? It's certainly evident in our youth. So how can we start to fix this?

COMMISSIONER SULLIVAN: You know,

first of all, I'm sorry you've had that kind of difficulty with your family, and I'm sorry for all the families that do.

There's a critical issue here that I think has to be faced, and the major one has to do with commercial coverage for mental health and substance use. There's a major problem here, and it's a parity issue. And for a long time commercial insurers have not been covering the kinds of services or covering them with the reimbursement to the extent that is needed to have a workforce willing to take individuals who have insurance.

While the Medicaid system is not perfect, there is more access and more availability through Medicaid to get mental health services, often, than through individuals who work and have private insurance.

This has been a problem for decades. What the state is doing I think is remarkable in terms of its efforts at this point in terms of parity. The parity, while it will

take a little more time to get this to work -- but over the past two years, the state has made a massive investment in parity, and we are getting medical necessity criteria that will be reviewed by the Office of Mental Health. We're looking at networks. Often networks can be phantom networks, which mean that, you know, you look at your insurer, it lists 20 psychiatrists, and you call them all up and they all say they're full or they can't see you or they don't have the time.

We are looking at all that. That's all coming through intensive work on the parity side.

Now, the important thing about parity is there's a law, but what happened over the years -- the law has been around for like over 10, 12 years -- the enforcement of it has been the issue. And the money that was in last year's budget that will be continued in this year's budget is the money to do that kind of enforcement. What we really need to do --

ASSEMBLYWOMAN MILLER: But we can't force a physician to join a plan.

COMMISSIONER SULLIVAN: It's not -- there are physicians sometimes in the plans that they don't have enough -- you can force the plans to pay enough to get physicians in their plan. That's their responsibility to have physicians available. When you pay your health insurance, if you want a cardiologist, you should be able to get a cardiologist. And if you're in a health plan and you want a psychiatrist, you should be able to get a psychiatrist.

So actually the onus on having the network that can provide those services sits with the insurer, and that's where the problem is. For decades mental health services have been underfinanced by those insurers, and that's what has to change. And you have to look at the parity laws, which say how do you determine how you allocate your money, you insurer, how much do you use for behavioral health services, what do you use for others, and how do you ensure that

individuals -- when you look across the country, the out-of-network use for mental health services is significantly higher than for any other medical service. Why? Because -- I'm sorry.

CHAIRWOMAN WEINSTEIN: Why don't you just finish your sentence.

COMMISSIONER SULLIVAN: Because basically the networks are not well established by the insurers. And that's something that the state is working on very hard with parity. It will take some time, but we hope it will significantly affect this.

ASSEMBLYWOMAN MILLER: Thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

Senate?

CHAIRWOMAN KRUEGER: Thank you.

We've been joined by Senator Betty Little.

And next up on deck, Senator Jim Seward.

SENATOR SEWARD: Thank you, Madam Chair. And thank you, Commissioner, for

being here and for your commitment to some of the most vulnerable citizens of New York, and providing services.

I wanted to identify myself with some of the comments of my colleagues already this morning in terms of the salary levels for those that are on the front lines, our direct care workers and other staff of our not-for-profit agencies who provide yeoman's work on behalf of those who are in need of services, and yet, you know, their salaries lag.

I know you've mentioned some of the efforts to try to bring them up. Of course, the Legislature has made a major commitment there as well.

I wanted to ask you to comment on the Executive's justification for continuing the COLA deferral for the second year and not restoring that in the Executive Budget.

COMMISSIONER SULLIVAN: The Executive has introduced the 2 percent targeted salary increases, which occur for direct care support workers in January and then will

occur again in April, at 4 percent. Those increases are in the budget and are there. That was in lieu of the COLA last year and in lieu of the COLA this year. And that was an agreement, is my understanding, between various parties including the Legislature last year, that as long as those -- that those targeted salary increases would be this year and last year, and not the COLA.

SENATOR SEWARD: I see. The -- there is an advantage of having it run through as a COLA in terms of the long-term stability of their salary levels.

COMMISSIONER SULLIVAN: Yes. Yeah. Mm-hmm.

SENATOR SEWARD: Shifting gears, we've already discussed the suicide prevention commitment regarding particularly veterans, law enforcement and our first responders. On the positive side, there's an additional $1 million in the Governor's proposal to help along that line. Can you comment on when this additional funding will be allocated?

And considering that the great need

that's out there -- we read it about it practically every day -- it's important that this funding be disbursed as soon as possible. And I would also -- as you look to the distribution of these funds, I would urge you to look toward regional balance of the funding distribution because we have many needs in the upstate region. In many ways it's even more serious, because of the distances involved.

So if you could comment on when these funds will be available and also on the regional allocation.

COMMISSIONER SULLIVAN: Yeah, we're going to try to move these funds as quickly as possible. It's not so much, I don't think, the availability of the funds as the planning to how to use them. And I think that's going to take a little time -- a couple of months, probably -- working with law enforcement, working -- we're going to be working with our state troopers across the state, we're going to be working with veterans as well -- this is for veterans and

first responders -- and with various EMS teams across the state, to discuss where is it most needed. Many -- for example, state troopers already do some work in this area. But where are the gaps? What are the things where we need to enhance? And what should a media campaign look like?

And when you talk about working with getting -- decreasing stigma, it's often very local, just as you said. You know, the same approach to working with the community in rural upstate New York or middle New York versus, you know, Long Island, it's very different. So we have to really plan out how we're going to use -- so there's going to be some time for planning. I don't think it's the allocation, so much, of the funds as making a plan sufficiently in-depth and with the right people to advise us as to how to do it. And that will take a few months to do.

So we're hopeful we'll be able to have something by the summer that will be, you know, able to begin to be launched.

SENATOR SEWARD: Thank you.

Just one final question. I know you're familiar with the Joseph P. Dwyer Veteran Peer-to-Peer Program. OMH staff has been invaluable in planning and implementation of these programs. And this has been a long-term commitment and priority of the Senate, and I'm pleased that that continues under the new majority as well.

And can you comment on the effectiveness of this program, the Dwyer Peer-to-Peer? And also, considering the importance of this program, why isn't there any funding in the budget proposal to continue this?

COMMISSIONER SULLIVAN: The Dwyer program has traditionally been funded through a legislative add, and it is in this budget as well.

As a program, it is -- yes, it's been shown to be very effective. It's a peer program, as you well know, where vets talk with vets. And I think that's probably been shown across the board to be one of the most effective ways to reach veterans, others in

law enforcement, et cetera.

So it's a good program, it's a solid program, but it has traditionally been funded by legislative adds.

SENATOR SEWARD: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Assembly.

CHAIRWOMAN WEINSTEIN: We go to Assemblywoman Walsh.

ASSEMBLYWOMAN WALSH: Thank you.

Good afternoon, Commissioner. I've been an attorney for 30 years, and a good part of that has been working in Family Court. For a while I prosecuted abuse and neglect cases, and a great, great number of cases in my caseload involved sexual offenders, sex offenders and intrafamily sexual abuse.

So I wanted to ask you about the Sex Offender Management and Treatment Act, SOMTA, and reform in that program. Can you explain how your proposed Sex Offender Management and Treatment Act reforms are going to be carried out?

COMMISSIONER SULLIVAN: Yes. The Sex Offender -- the SOMTA programs are for those individuals who are leaving prison who have been civilly committed to -- now to the SOMTA program. The average stay in that program is something like five years, so most of the sex offenders are very serious, high-level sex offenders.

When the legislation was first passed, it was done under the auspices of a hospital-based approach. And the science in terms of working with this population, as well as our experience over the past years, has been that basically you want more of a psychosocial rehab approach, which helps people change hopefully their behaviors which have led to the sex offender status.

So we're really redefining programmatically what's going to be happening. To do that and do it well, you needed to kind of move the auspices under something called secure treatment and rehabilitation in order to, for example, hire more psychologists, hire more -- others who

are skilled at a certain level of treating that particular population.

And we're hopeful that by redesigning it, we can even be more successful. We've been able -- some individuals have been able to leave, very slowly, very carefully, back into the community. And we're hopeful that working with this new model will be even more effective. Currently there's about 385 individuals in civil commitment.

ASSEMBLYWOMAN WALSH: Okay. And will these reforms involve the movement of patients from one facility to another, or will patients be just segregated in their current facility?

COMMISSIONER SULLIVAN: They will stay exactly where they are. They will stay in the same facilities, the same degree of security -- everything will be the same. It's really just the clinical programming that's shifting, not the location or the legal status. It's the same.

ASSEMBLYWOMAN WALSH: And as I said before, you know, my experience told me that

sex offender treatment is some of the most difficult treatment that's out there. It's very, very difficult to break that cycle. So are patients going to be getting any new treatment that they're currently not getting?

COMMISSIONER SULLIVAN: It will be more focused on what we call a psychosocial rehab approach -- more groups, more ability to work really on the -- on learned behaviors which you're trying to unlearn. And more focused on cognitive kind of work.

So yes, it will be an enhancement of what they're currently receiving, we believe while being able to move to a certain level of expertise with the clinicians that will be in that program.

ASSEMBLYWOMAN WALSH: And when do you think that that new approach is going to be effective, taking effect?

COMMISSIONER SULLIVAN: Well, we'll start on -- if the legislation is passed, we'll begin right away. And probably it will take a while to do all the training and things that are necessary. But I would give

it six months to nine months, we should have in place the changes, and then we'll evaluate them.

As you have said, this is a very thorny issue and we are trying to really provide the best evidence-based practices for individuals in the sex offender treatment program, but that is a very difficult group to treat.

ASSEMBLYWOMAN WALSH: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Senator Luis Sepulveda.

SENATOR SEPULVEDA: Good morning, Commissioner. Thank you, Madam Chair.

Commissioner, as you may or may not know, the issue of suicide is very personal to me. When I was 11 years old, my mother committed suicide. She suffered from mental illness, and unfortunately back then 40 years ago, 45 years ago, we didn't have the services that we have today.

But her manifestation started when she was a child. According to mental health advocates, 54 percent of children with mental

health or behavioral conditions that needed treatment in the last year did not receive treatment. Additionally, suicide is the second leading cause of teenagers between 15 and 19. Amongst Latinas, it's the second leading cause; amongst African-American young boys, same amount. Over 40 percent of the LGBTQ community also has considered suicide or engaged in suicide ideation.

In 2011 the original Medicaid Redesign Team found that children's mental health services need more resources and capacity and should not be cut. Nine years later, the Children's Behavioral Health MRT Subcommittee is still working to implement reforms that will expand children's mental health, addiction and care coordination services.

So my first question is, should there be a moratorium on children's mental health cuts while the full reform and transition to Medicaid managed care is going on?

COMMISSIONER SULLIVAN: There are no projected at this point in time. That reduction in the rate that was there for

start-up -- I explained that -- has been reduced. But the overall plan, which includes those services being expanded to serve even more youth going forward, is still in place, and the commitment to continue that expansion of services, which at various points has been estimated to be an additional 30 to 60 million over the next couple of years as these services expand.

The newer services are very community-based home-based services, and they include things like psychiatric home-based services, other licensed providers being able to go into the home. All these services are now being started up and are growing. As they grow, they are expected to increase the services for youth, especially youth at high risk that need intensive services.

So at this point in time the growth of that program, which is what -- the way it was planned through the MRT and the way all those services were provided, is continued. And the investment in that is still in place.

SENATOR SEPULVEDA: So there haven't

been any cuts, or there are no projected cuts?

COMMISSIONER SULLIVAN: No, there has been a cut -- there has been a reduction, a planned reduction, which was always there, for the start-up dollars. Which was supposed to only last a year. So those dollars, yes, have been reduced and have stopped as of January 1st.

But the overall program is still embedded into the Medicaid dollar.

SENATOR SEPULVEDA: Well, I will strongly encourage and implore you not to cut any -- at any level, because, you know, we have to start at the -- when they start manifesting mental health issues at a young age and we don't treat it, any cut to me, I think, is unacceptable.

And then will the work of the Children's Behavioral Health MRT Subcommittee be addressed by MRT II? Or will MRT II be asked to defer to the ongoing work of the children's subcommittee without any sort of inference?

COMMISSIONER SULLIVAN: Basically those plans are still being discussed, so I can't answer that at this time.

SENATOR SEPULVEDA: They're still being discussed?

COMMISSIONER SULLIVAN: Yeah.

SENATOR SEPULVEDA: And when do you think --

COMMISSIONER SULLIVAN: The -- I'm not sure. Within the next several weeks when various other things are decided about the MRT.

SENATOR SEPULVEDA: All right. So I can follow up with you on that once we have further information.

COMMISSIONER SULLIVAN: Yes. I'll be glad to follow up with you, yes.

SENATOR SEPULVEDA: So now my next question is really based as the chair of Corrections. In the past budgets you've proposed getting rid of 50 mental health beds devoted to jail-based competency restoration, and the Legislature has outwardly rejected it. Are you again proposing to close 50

beds?

COMMISSIONER SULLIVAN: We're proposing jail-based restoration, which would basically enable a county to decide to do restoration to competency, the ability to stand trial. In a jail, versus having to transfer that person by statute to a hospital. Basically saying based on medical necessity.

You can do outpatient restoration for individuals who are not in the prison or jail system. So outpatient restoration is something that can be done. And what we're proposing is that that outpatient restoration be done in an appropriate program which will be staffed appropriately, followed on the best practices in other states.

So the jail-based restoration, what it basically does, it enables individuals to be closer to home and to get the services they need in the jail without having to be transported for competency to a hospital if that's not medically necessary that they go to a hospital.

SENATOR SEPULVEDA: I've seen some examples of that in some of the facilities, and I'm completely dissatisfied with what I've seen. I don't think that the services that are provided are adequate in Corrections.

COMMISSIONER SULLIVAN: Well, just to say there is no other jail-based restoration at this point, though. This would be a distinctive program, that's all.

SENATOR SEPULVEDA: Right. But in facilities where they actually provide or attempt to provide --

COMMISSIONER SULLIVAN: Yes, that's a different issue, yes.

SENATOR SEPULVEDA: -- mental health services, I think it's been a complete disaster. And I've spoken with providers for this; there's not enough money, there's not enough services. And so that's another issue that I think we should have a discussion about.

COMMISSIONER SULLIVAN: Okay. Glad to.

SENATOR SEPULVEDA: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Assembly?

CHAIRWOMAN WEINSTEIN: We go to Assemblyman Ra for a question.

ASSEMBLYMAN RA: Thank you.

I just wanted to ask about -- I know there is an increase of $12.5 million for new adult home beds, beds and services, in the Aid to Localities budget proposal. Is there any information on where those might be located in the state?

COMMISSIONER SULLIVAN: The adult home beds are connected to an adult home settlement, which by and large is New York City. So they're tied to a legal settlement and geographically. So those particular adult home beds are locked in. And they're primarily in New York City.

ASSEMBLYMAN RA: Okay. Thank you.

CHAIRWOMAN WEINSTEIN: So we go back to the Senate now.

CHAIRWOMAN KRUEGER: Thank you.

Senator Borrello.

SENATOR BORRELLO: Thank you, Madam Chair, appreciate it.

And thank you, Commissioner Sullivan, for being here today. It's nice to meet you in person after talking on the phone several times.

And first of all, let me say thank you very much for your involvement and your team's involvement with a critical issue we're having in my district with Lake Shore Hospital. And it leads to my question, particularly on mental health services in rural areas.

You know, we are now facing a shortage of beds throughout the state, yet the closure of Lake Shore Hospital is going to see the decommissioning of 20 critically needed beds in that region. On top of the other challenges we face, my question is is that it appears to me -- as a former county executive and a person who lives in that immediate area, it appears to me that the Department of Health and OMH were not in coordination on this. The left hand of state government

doesn't know what the right hand of state government is doing. And we have a crisis in our rural communities when it comes to mental health services. And yet we are closing beds unnecessarily. And DOH is being myopic in their view of the services -- the holistic view that's required of the services that are really critically needed in our area.

So my question to you is how can we justify allowing beds to be decertified, and what can be done to preserve those and ensure that in the long run that DOH and OMH are coordinating their efforts to provide vital healthcare services to our regions, especially in the rural areas?

COMMISSIONER SULLIVAN: Thank you. You know, we work very closely with DOH on these issues and on the complement of beds that are needed for a particular area, both on the mental health side and obviously DOH is concerned on the medical side as well.

I think that, you know, it's just a historic fact that psych beds, mental health beds do not have the financial margin, by and

large, that other medical beds have. So sometimes hospitals decide that, you know, for financial reasons they need to lower psych beds. That's always a serious issue, because we don't have as many as we might need, and we need to work very closely with those hospitals to make sure that there's enough services in the area.

And that's what we're trying to do in the area which will be impacted by TLC. And we are looking to see where we might be able to grow other kinds of services. Sometimes hospitals have been very helpful, even if they close beds, in establishing more outpatient ambulatory services. So we always work with communities to try to make this happen. Sometimes hospitals move quickly on this, quicker than we want them to, before plans are available, and then we -- sometimes we resort to regulatory responses to that.

But the reality is that we have always worked very hard and worked together across the state to try to provide the services that communities need.

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

Thank you.

COMMISSIONER SULLIVAN: Thank you.

CHAIRWOMAN KRUEGER: Assembly.

CHAIRWOMAN WEINSTEIN: We go to Assemblywoman Gunther.

ASSEMBLYWOMAN GUNTHER: So I have a few questions. The Executive has proposed removing pre-admission certification committees to determine a child's need for residential treatment. What will the role be of a newly created advisory board within the Council of Children and Families?

COMMISSIONER SULLIVAN: I think that the new advisory board will help us not just with admission criteria and census, et cetera; they'll help us with the design, I believe, of the RTF system.

The Council on Children and Families is a very active council, and I think they can talk with us about the needs of communities and the kinds of design that we need in these facilities. By changing the PACC admission process, it also gives us the flexibility to do some creative work with the RTFs across the state. And in particular,

many of the upstate RTFs are particularly happy with this change because it gives more flexibility in both admissions -- the kinds of admissions and the kinds of services that can be provided.

So we think it's a really good move, and many of the upstate groups such as Northern Rivers and Parsons are very involved and are very happy that we've modified the PACC admission process.

ASSEMBLYWOMAN GUNTHER: Can you give me examples of what type of behavior would lead to the insurer being fined?

Also, regarding children's behavioral rates, you say that you have start-ups. But when did they actually begin?

COMMISSIONER SULLIVAN: Excuse me, an individual's being fined, is that relative to parity?

ASSEMBLYWOMAN GUNTHER: Yes.

COMMISSIONER SULLIVAN: Yes. Well, there will be regulations that will be posted as of October of this year which will clearly outline in great detail the various kinds of

things that insurers must respond to, and they could possibly lead to fines. So that compliance program is in this year's budget. And it's stated that basically as of October we'll have those regulations out, which will make it even clearer what can lead to what kind of repercussions if you're not following the parity regulations.

At this point in time we have already received all the medical necessity criteria from the various insurers, we're reviewing them, and how the compliance program will be set up to make sure that they do it should be established by October. And then we'll see, as a result of those regulations, what the fines will be kind of connected to that.

ASSEMBLYWOMAN GUNTHER: So I think there was about 1.5 million. Where did the money go?

COMMISSIONER SULLIVAN: No, that hasn't happened yet. I mean, there was an estimate that that might be the level. If that money were to occur.

ASSEMBLYWOMAN GUNTHER: So where would

it go, then?

COMMISSIONER SULLIVAN: It would go to the ombudsman program, the CHAMP ombudsman program, which would then use that money to further the efforts of parity, educating families dealing with denials, et cetera. If it occurs.

ASSEMBLYWOMAN GUNTHER: You also -- the other thing is like with the rates for housing. So the new stock, they get an increased rate, where old stock, they don't get the same amount of money for their rentals for people --

COMMISSIONER SULLIVAN: The 20 million, though, is going towards older housing which is already there, all types of housing. In the past sometimes we've limited it to specific housing; now it's any kind of housing can be eligible for that $20 million, and it will also be spread across the state.

ASSEMBLYWOMAN GUNTHER: Okay. Thank you.

CHAIRWOMAN WEINSTEIN: Senate?

CHAIRWOMAN KRUEGER: Thank you.

Senator Akshar.

SENATOR AKSHAR: Madam Chairwoman, thank you.

Commissioner, always good to see you.

Let me go specifically to the Greater Binghamton Health Center. Are there any conversations happening about a reduction in beds, either adult beds or children beds?

COMMISSIONER SULLIVAN: No.

SENATOR AKSHAR: Good. That's good news. Thank you.

Let me move, if I may, to mental health services in the public school system. What type of money are we investing as a state to address that issue? It's an issue, at least from my perspective, that is at crisis levels. Any school superintendent you speak to will tell you that they are dealing with mental health crises on a daily basis.

So what is our investment to deal with that statewide?

COMMISSIONER SULLIVAN: One of the major initiatives is to increase the number of school-based mental health clinics, which

we've been successful in doing. What you do is you work with a community-based provider who then works with the school to set up a satellite in that school, on site. Usually it's a social worker, but also now some of these are also using telepsychiatry to beam in psychiatrists to work in the school, and they can provide the services on site.

That has worked in 800 schools so far, and we're working with all the school districts to increase that.

In addition, the work which is done by the Mental Health Education Act, in conjunction with the schools, has set up an entire ability to begin to look at the social/emotional wellness from early on in the schools, from kindergarten through 12th grade. So all the work on curricula, et cetera, is something which is also jointly done by the Department of Ed and also by Mental Health.

In addition, we do lots of crisis trainings in schools, lots of suicide prevention in schools. We have a whole

suicide prevention plan -- guidelines which we just printed as of about a month ago and we're distributing to all these schools as to how to set up a tiered approach to working with possible suicide issues in their schools. And we're available for all kinds of technical assistance with them.

We've also done some pilots of some very intensive work in schools, including something called ParentCorps, which works with the pre-K population and does parent teaching for schools. It's limited, but it's something that we are looking at to see if it might possibly grow.

And we also have, across the state in some schools -- five districts in the state, most of them upstate -- called Promise Zones, where there's an investment in dollars that come to the schools to come together with community-based providers so that schools not only have clinics on-site, but they also understand all the community-based services that are available and work in partnership.

So there's a number of initiatives

going on across the state. But the mainstay is trying to get more and more satellite clinics into schools. Because they not only -- they see individual kids, they work with teachers, they help educate the teachers, they help work together to solve problems. So that's probably one of the most effective ways to help the schools.

SENATOR AKSHAR: Could you quantify, though, in dollars what we're investing in the public school system to address the issue?

COMMISSIONER SULLIVAN: I don't know if I could give you the exact dollars. I could work on that to give you how all these things add up. But I don't have it kind of off the top of my head exactly what that would be.

But I'll get back to you, Senator.

SENATOR AKSHAR: Let me ask you I guess a more direct question. Do you think the investment that we're making in the public school system is significant enough to address the underlying issue?

COMMISSIONER SULLIVAN: I think -- you know, in some ways you can always do more. I think this is a very, very strong beginning. I really do believe that on-site work -- you know, there's a lot that can be done with trainings and education. But on-site availability I think is one of the most key things.

Many years ago I had a school-based program when I worked in Queens, and basically it was marvelous the difference it made in a very troubled junior high school.

So I think that on-site capacity is really critical, and so we're putting a lot of our energies into getting that available, so that when you're in a school and you have a youth that you might be concerned about, you have someone you can consult with, go to them, get some feedback, help them get the services.

So that's -- we're doing that. We're doing all the other things too, but I think that's a critical piece.

SENATOR AKSHAR: So I just want to

thank you publicly for all the work that you are doing in the initiatives that you speak about.

But we're falling short as a state. This is not -- this is not a knock on you or anybody who works in your office, because I believe in my heart that you're doing the very best you can with what resources you get. But for me this comes down to wants versus needs.

When I look at the Joseph P. Dwyer program, the investment, $3.7 million, it's a remarkable program, but that's a paltry investment. Last year there was a million-dollar grant provided for schools to compete against one another to address some of their mental health issues.

You know, nobody knows the scope and the difficulties of providing these services better than you and the people that work for you. I would argue that we are really at a crossroads in this state. And when I see the Executive make a suggestion that we would invest $300 million in the restoration of the

Erie Canal, but yet only invest $3.7 million in a program like Joseph P. Dwyer or have to fight over dollars to provide mental health services in schools, again, I think we're falling short and we need to do a much better job.

Madam Chairwoman, thank you for the time.

CHAIRWOMAN KRUEGER: Thank you.

Assembly.

CHAIRWOMAN WEINSTEIN: We've been joined by Assemblywoman Buttenschon, Assemblyman Weprin.

And we go to Assemblywoman Miller for a question.

ASSEMBLYWOMAN MILLER: Hi again. For the behavioral health ombudsman, where is the funding coming from for that? Is it coming from the penalties that are deposited to the fund? And if that's the case -- I'm just jumping the gun -- if that is the case, does the ombudsman start or does it have to wait for the program to get funded from that --

COMMISSIONER SULLIVAN: Sorry. It was

actually started last year. There was an allocation in the budget last year for 1.5 million for the ombudsman program. They've already seen about 1600 clients and I think have done 5,000 educational -- so they've done a lot of work.

If fines are levied, that's additional dollars that would then go in addition, on top of the base funding, which is 1.5 million.

ASSEMBLYWOMAN MILLER: Thank you.

CHAIRWOMAN WEINSTEIN: Senate.

CHAIRWOMAN KRUEGER: Senator Sue Serino.

SENATOR SERINO: Hello, Commissioner, and thank you for being here today.

This is always a very sensitive subject to me; I lost my brother by suicide 10 years ago, and I've been very open about speaking about it from the time of his obituary and trying to get rid of that stigma.

And I know in 2018 we had passed a bill that was -- not passed, I'm sorry, we

introduced a bill that would establish the mental health services program coordinator that would reimburse the schools for hiring these professionals. And I know Senator Akshar had spoken about that, and you mentioned that there are 800 schools that have some type of a pilot or a program.

But I know in my district I'm hearing from kids -- and it doesn't matter if it's in a wealthy school district, a poor school district, middle class, they're all saying that they're not getting enough help. And I know that we don't have the beds for our children too. Nobody wants to go into a lockdown emergency services facility and then -- you know, it's kind of scary, especially for a kid, and then to think that they're going to go back there again.

So I just wonder, you know, where those 800 schools are, because I'm not seeing it in my district.

COMMISSIONER SULLIVAN: They're spread across the state. There are more of them upstate, actually, than downstate. But I can

get you exactly how many might be in Staten Island. I'm not sure off the top of my head which ones, but there are several -- not several, there's a number in the city, probably about 25 to 30 percent in the city and the rest are upstate.

We've been working with the Department of Ed in the -- trying to work with the Department of Ed in the city to kind of foster more ability to have mental health clinics in the schools. But I can -- I'll definitely get to you on what's available in your district.

SENATOR SERINO: Thank you. And I liked hearing about the telepsychiatry too. I think it's great, especially when you live in a rural community. As far as seniors, you know, we have a lot of seniors that suffer from social isolation. And is there anything that you're doing with the telepsychiatry for our aging seniors? I'm the ranker on the Aging Committee and was wondering -- I'm just joining the mental health committee now, so I'm just wondering if there are any services

for the seniors as well.

COMMISSIONER SULLIVAN: There's a mental health association in upstate New York that has done a little bit of a pilot with the elderly in terms of a telegroup where -- dealing with the issue of social isolation, where people can get together, talk via -- they're a combination of tablets and computers -- with a great deal of success.

So we're looking into that in terms of some of the approaches that we have with the elderly. Social isolation is a huge issue, by and large, and we're probably not using technology the way we should be. So that whole -- telemedicine is something that we have significantly expanded the ability to do and to bill for. Now I think we have to get the word out there and get creative about how we use it.

And I think that one of the creative ways can be, you know, kind of group therapy through -- which now could be reimbursed by Medicaid, we're still working sometimes with the commercial insurers. But you could do

that for the elderly across a group.

So we'll definitely be expanding that. And I thinking that that really is a big piece of the future. And it's also a way to increase access and to deal with the workforce limitations. So there's a great deal that can be done with that.

SENATOR SERINO: That's very encouraging.

And then I just want to echo the sentiments that my colleagues have mentioned about the Dwyer, the Peer-to-Peer Program. We first received it my first year in the Senate, and it's been wonderful working through Mental Health America, through the county. It's just great. And I wouldn't want to see any additional money that's put in the budget for mental health -- you know, like not robbing from Peter to pay Paul.

It's bad enough that our guys have to come up here every single year and kind of -- you know, they schlep up here and they beg for that money for the Dwyer program, where we -- and I know that that's not you, but

it's where -- you know, we keep fighting for it, and I don't want to see the extra money, the million dollars that are going to help our law enforcement, first responders, everybody for mental health, you know, be taken, you know, one for the other. I think it's all vitally important.

Thank you.

CHAIRWOMAN KRUEGER: Thank you.

CHAIRWOMAN WEINSTEIN: I have a couple of questions. But before that, just wanted to say that we've been joined by Assemblywoman Carmen De La Rosa.

And I want to switch to a question about jail-based restoration. So the Executive Budget includes 1.7 million in net savings related to the development of specialized beds in local jails to restore felony-level defendants to competency. And I'm wondering if you might comment or if you know the fiscal impact on jail based -- that this jail-based restoration would have on counties, since they'd now be required to pay 100 percent of the cost beginning on April 1.

Are the counties both financially able to take on that responsibility, and do we have any concern about how the -- now that the counties would be doing this, how it would affect the quality of services provided within the local jails?

COMMISSIONER SULLIVAN: The counties are currently paying 50 percent of the cost of hospital-based restoration, which is about $130,000 a year. So it's quite high, because it's hospital-based care and treatment. When it goes to 100 percent, that would be $130,000 for -- pretty much the cost per restoration to competency.

Jail-based restoration is about a third of that cost. So jail-based restoration would leave probably a cost to the counties of about 35,000 to 40,000 per jail-based restoration. So that's one of the incentives perhaps to do jail-based restoration.

The problem here is that individuals are getting hospital-based care for restoration when they really kind of only

need outpatient level of care. And so the counties are paying a very high cost even now, and it will get higher with the 100 percent cost.

CHAIRWOMAN WEINSTEIN: Thank you for that response.

Senate?

CHAIRWOMAN KRUEGER: Thank you. Second time, David Carlucci.

SENATOR CARLUCCI: Great. Thank you, Chair.

Thank you, Commissioner, for your time today. I'll try to be as brief as possible. I just had a few more points I wanted to go through with you.

First, the streamlining preadmission process for residential treatment facilities, it looks like we're going from a 30-day wait to 15 days, which looks good on paper. I just want to hear from you how we safeguard this process and make sure that it's actually working to the extent of what we have here on paper.

COMMISSIONER SULLIVAN: We're going to

be monitoring it very closely. The individuals who -- there will still be a review by a physician who will be designated by me to kind of take a look at those admissions and make sure. But we should be able to reduce the time drastically because prior it required a number of committee steps, you had to have a group meet, which only met once a month. I mean, that's now -- there will be timely meeting, there will not be this once-a-month meeting, you can get a review done in a day or two so that we can get the information back.

So it should streamline the process, but we're going to be monitoring it very closely to make sure. I think it will be less than two weeks, but we're targeting, to be sure, two weeks.

SENATOR CARLUCCI: Yeah, I hope so. Well, thank you.

And then back to the jail-based restoration program, I know last year the Governor had put this in the Executive Budget. But the difference is -- same

proposal as this year, but the Governor was offering money to the localities that opted into this program.

I'm concerned for a few reasons. First, that we're putting in a $1.7 million savings into the budget. And it looks like the Governor is anticipating that municipalities will join onto this program. The concern I have is that -- and I'll let you answer. My concern is that municipalities will not opt into this program because there's no dollars coming forth to make the upgrades necessary to meet these needs.

Can you speak to the jail-based restoration program and how you see it making those savings? And have any municipalities expressed interest? Are any municipalities ready to go with no additional funding?

COMMISSIONER SULLIVAN: There are some municipalities who have expressed interest. No one has said at this point this year that they are ready to start, partly -- the one municipality that had been, in the past,

wanted to just wait and kind of think about it again because of some of the changes.

But jail-based restoration would basically reduce the cost to the counties of what they were paying now and will pay in the future to have inpatient hospital restoration.

Yes, there would be some start-up that might be needed in terms of getting this started in the counties, but that should be not that much. And basically, even without the additional dollars which were there in the year before, which were really startup dollars -- even without those dollars, it should still be financially in the interest of the counties to do this because the cost of inpatient hospital-based restoration is so high.

And this would only be for counties that were big enough to have a large enough population that would benefit from this.

SENATOR CARLUCCI: So the $1.7 million in savings -- that's savings to the State of New York -- what now is the cost? Do we bill

the municipalities for that psychiatric care when an inmate is unable to -- when they are referred to the psychiatric facility? What type of reimbursement are we talking about?

COMMISSIONER SULLIVAN: The average cost is a thousand dollars a day in a hospital. And the average time -- that's average time, so for some it could be more or less -- is about three -- almost four months, almost 140 days to restoration to competency. So the actual dollars is close to -- on average, is about $140,000 which counties would now be paying, per restoration, to the state.

SENATOR CARLUCCI: What is currently happening? When they send someone to the facility, is the state rebilling the county for that?

COMMISSIONER SULLIVAN: Currently, yes. The county gets billed currently 50 percent. In New York City they have been billed for the past year also at a hundred percent.

Going forward, the counties would be

billed -- all counties would be billed for a hundred percent.

SENATOR CARLUCCI: So, wait, what is it now?

COMMISSIONER SULLIVAN: Right now this year -- prior to this year, counties were paying 50 percent of the cost of the hospital-based restoration, which is about -- which was about $70,000 per restoration. If you -- but New York City, as of last year, was paying a hundred percent of the cost.

Going forward, all counties will pay a hundred percent of the cost of the hospital-based restoration.

SENATOR CARLUCCI: And why is New York City excluded from this proposal?

COMMISSIONER SULLIVAN: They're -- they -- there wasn't any interest at the time in New York City. And partly it's the way they are established, the way they have pre-arraignment hospital -- the way they're established doesn't really fit for the need for jail-based restoration. It really is a program that is best-served upstate.

SENATOR CARLUCCI: Thank you, Commissioner.

CHAIRWOMAN KRUEGER: Thank you.

The Assembly is done. I'm just going to do one question in closing for you, Commissioner.

So my last two colleagues asked you about the program in the local jails, mental illness. In the General Welfare/ Human Services hearing we had last week, one of the discussions was that approximately 3200 people are released from the prisons directly into the entry point for the New York City Men's Shelter. A disproportionately large number of them suffer from mental illness. That surely can't be a smart discharge plan for someone with mental illness: Okay, we're letting you out of jail, and welcome to the streets of New York.

I'm going to ask this in the Public Protection hearing of DOCCS, but can you please tell me what the right answer should be? Because I know that this can't be the right answer.

COMMISSIONER SULLIVAN: Well, we know that basically if individuals with serious mental illness leave prison, that they do best when they are in housing which is supported by a series of services that enhance their ability to reenter into the community.

We do a lot of work in the prisons before they are discharged to help the seriously mentally ill get ready to go into the community. And just last year -- and we're in the process of putting forward these units, 250 additional apartment units were authorized for individuals leaving the prison system at the highest need, to be able to move to housing which would be run by the particular agencies that do very good work with the forensic population.

We try as best as we can for most of the seriously mentally ill leaving to get into some degree of housing, whether it's apartments or other kinds of family housing, whatever is possible. Some of the seriously mentally ill do unfortunately end up going to

the shelters, sometimes for -- hopefully, as often as possible -- for a briefer period of time waiting to get into the other housing. But we do the best we can to try not to have them go to shelters, because you're right, it's not the best disposition.

CHAIRWOMAN KRUEGER: But you are working with or IDing people in prison as suffering from mental illness.

COMMISSIONER SULLIVAN: Oh, yes. Before discharge we know all the individuals who are seriously mentally ill. We also know their risk levels. So we prioritize for the high-risk clients to be able to go out into housing. Some of the lower-risk clients, unfortunately sometimes we don't have enough housing so they go to the shelters.

But every client who leaves is assessed for their ability to go. And if they are assessed before they leave prison to need additional help before going, they go to one of the pre-discharge units in the prison system. We have two of those, and we're going to be expanding to another one, where

they spend anywhere from several months getting ready to leave the prison system to reintegrate into the community.

CHAIRWOMAN KRUEGER: And at that time you're attempting to find them someplace where they would move to as opposed to the shelters or the streets.

COMMISSIONER SULLIVAN: Yes. Yup, absolutely. Yes.

CHAIRWOMAN KRUEGER: And is there some kind of data report you can get for me and my colleagues --

COMMISSIONER SULLIVAN: Yes.

CHAIRWOMAN KRUEGER: -- showing -- that would be very helpful.

COMMISSIONER SULLIVAN: I can show you -- we have the numbers and we have where the individuals go, how many go into them. We can definitely get that to you. Be glad to.

CHAIRWOMAN KRUEGER: Thank you very much for your time with us this morning. You are now free.

(Laughter.)

CHAIRWOMAN KRUEGER: Well, you might

not be free, but you're allowed to leave this room. Let's not go too far. Sorry.

Our next witness is the commissioner of the Office for People With Developmental Disabilities, Dr. Theodore Kastner.

Good afternoon.

COMMISSIONER KASTNER: Good afternoon, Senator.

Good morning, Chairs Krueger, Weinstein, Carlucci and Gunther and other distinguished members of the Legislature. My name is Ted Kastner, commissioner of the New York State Office for People With Developmental Disabilities, or OPWDD.

Thank you for the opportunity to provide testimony about Governor Cuomo's fiscal year '20-'21 Executive Budget and how it will benefit the more than 140,000 New Yorkers with developmental disabilities served by OPWDD.

It has been just over a year since I assumed leadership of OPWDD, and I'd like to begin my testimony by highlighting some accomplishments of the past year. In regard

to our work with our partners, in 2019 we received federal approval to provide crisis services for individuals with intellectual and developmental disabilities, or CSIDD. This Medicaid State Plan amendment allows us to double our service capacity with the same investment of state dollars. We will use these funds to complete our statewide network of crisis response services.

We're collaborating with the Office of Mental Health to create new programs to support individuals with severe, challenging behaviors. These include a new inpatient unit in Brooklyn and a new extended treatment unit in Queens. We're exploring avenues to enhance the skills of primary care and behavioral health providers.

Complementing these efforts, we're working diligently to improve collaboration with our partners in county government. We have regular meetings with the counties and are exploring opportunities to coordinate state and county resources to improve crisis response outcomes.

We've achieved our goal of ensuring that all OPWDD-eligible individuals have a life plan developed by our care coordination organizations, or CCOs. We're now working to ensure that these life plans meet the standards of being conflict-free and person-centered.

In August of 2018, OPWDD published the draft Specialized IDD Plans-Provider Led, or SIPs-PL, qualification document for public comment. We anticipate releasing a revised draft for public comment soon.

Internal activities in 2019 have helped lay a foundation for a more effective system of support in the future. We have restructured our leadership team and are working to improve public engagement through our advisory committees. OPWDD conducted a thorough review of the organizational structure and functions of approximately 20,000 employees to ensure that resources are deployed to best meet the needs of people we support.

We created a new Division of Data

Management and Strategy to enable better-informed decision-making and to promote data transparency. This will support IT development and data analytics.

We're midway through the implementation of an electronic health records system for all state-operated services. We've secured a five-year renewal of our federal Medicaid waiver, allowing us to support more than 90,000 people in their own home or community.

And finally, OPWDD strengthened central office oversight of policy, budgeting and program operations and has now begun to reorganize the regional office structure to streamline operations.

As a result of all these improvements, all individuals and families have the same access to supports and services no matter where they live, what language they speak, their race, religion or when they became New Yorkers.

The Governor's Executive Budget continues to build upon these successes,

including significant new investments now leveraging approximately $9 billion in state and federal funding for OPWDD services and programs. These include $120 million in annual all-shares funding to provide new and expanded services for people entering the OPWDD system for the first time; $15 million in capital funding to expand housing opportunities; and $170 million in new state and federal resources to comply with the state's minimum wage, to increase wages for direct support professionals, and to support our clinical staff employed by OPWDD's network of nonprofit providers.

These additional human capital investments bring the total commitment to increased wages and compensation to our nonprofit provider workforce to $650 million since 2015.

New York leads the nation in the amount of funding to support people with developmental disabilities, providing twice the national per-capita average. As we move into 2020 and beyond, OPWDD will continue to

transform the delivery system to one that is more accessible, equitable and sustainable. New York's evolution to be a more responsive and flexible service system would not be possible without our collaborations with the Legislature, the input of the people we support and their family members, and our dedicated partners in the provider community.

Thank you for your partnership, and I look forward to answer any questions you may have.

CHAIRWOMAN KRUEGER: Thank you.

Our first questioner will be Chair David Carlucci.

SENATOR CARLUCCI: Thank you, Chair.

Thank you, Commissioner, for your testimony today, and for your commitment to our most vulnerable populations. And I know we've spoken at length about the need to support our workforce. It's the backbone of the developmental disability system. And it's a struggle that we still have. Every day I hear about the concerns and the complaints about the transition of the

workforce. And you can't blame them when they're paid minimum wage or just above, in some cases, to do the hardest work. And that transition is just -- it really eats at the quality of care.

So my hat goes off to the professionals, the people that -- the DSPs that have been there, that have done it as a career. They pull together because of their love and commitment to the people they serve, so I thank them for that.

I first wanted to get into -- because we'll get into the workforce, but the big pressing issue is about the transition to managed care. And we've heard about this, but yet it's something -- little details have been provided, at least that I'm aware of. Is New York still moving to -- are we still transitioning to managed care? And if so, what is the time frame?

COMMISSIONER KASTNER: Thank you, Senator. We have a process for the transition to managed care. At the present time there are two primary components to

that. The first was in July of 2018, we launched our care coordination organizations. The effort was designed to expand the scope of our case management program and to incorporate healthcare services in addition to habilitative services, into what we now call a life plan. So our care management system is now building the competency to be able to incorporate both health and long-term-care services.

In August of 2018, we published the draft SIPs-PL qualifications document. We received about 80 public comments on how that document could be enhanced. We've been working on revisions to that document while we're simultaneously working to ensure that our CCO launch has been effective. We are near the end of completing a revision to that draft SIPs-PL qualification document, and we expect that draft to be made available to the public soon.

SENATOR CARLUCCI: What do you think, how soon?

COMMISSIONER KASTNER: I think soon.

(Laughter.)

COMMISSIONER KASTNER: I have to say I --

SENATOR CARLUCCI: Because we've kind of heard that before.

COMMISSIONER KASTNER: I've said this before. Actually, I went on record in saying in September it would be out in October or November, in November it would be out in December, and obviously I've been wrong on both counts.

So I'm a little uncomfortable saying that it will be a specific date, although we do expect it to be out shortly.

SENATOR CARLUCCI: Okay. And one of the big concerns that we have is obviously that -- the difference between state-operated and voluntary services. Do you have an idea or a breakdown of what percentage of the covered population is covered under state-operated work and the nonprofit work? Do you have any idea what the breakdown is?

COMMISSIONER KASTNER: Yeah, a rough ballpark is approximately 20 percent of the

service delivery system is provided through OPWDD state employees and 80 percent through the voluntaries. For residential, it's pretty easy to look at: About 30,000 certified residential opportunities through the voluntaries, about 7,000 certified residential opportunities through OPWDD.

SENATOR CARLUCCI: One of the concerns that we keep hearing about the transition to managed care is that there would be start-up costs that possibly have to be put out. Can you tell us, is that -- would that be true? Can we give a guarantee? Can we put people at ease to say that no money from services would be taken out in order to meet those start-up costs?

COMMISSIONER KASTNER: We have said that in the past. We do not have start-up costs in our operating budget, and we believe that that is still the case. The operating costs for administration and start-up would come from another source.

SENATOR CARLUCCI: Okay. And does there seem -- when we talk about we have the

80 percent that's run outside of the OPWDD state-run system, does OPWDD track the fiscal health of the nonprofit providers?

COMMISSIONER KASTNER: Yes, we do. Our providers are compensated through a cost-based reimbursement mechanism. So for a base year they submit to us the list of the costs that they incur in providing services to our individuals. We incorporate that information into the rates that are paid to them. It's probably the most favorable reimbursement methodology that could be used to provide payment to providers, because it's based on their historical costs.

SENATOR CARLUCCI: I'm sorry, what was that last part you said?

COMMISSIONER KASTNER: It's a very favorable reimbursement methodology. As opposed to a fee or a capitation arrangement, payment based on costs actually makes providers whole as a result of, you know, being fully compensated for the services they're providing.

SENATOR CARLUCCI: Okay. And we have

been pushing, we've got the BFair2toDirectCare campaign. We were successful in putting some money into the budget last year. I had asked the commissioner of OMH the same question about we're hearing about that the 2 percent increase has not been put out the door yet, and that's putting many of the providers at a very challenging cash-flow situation.

Can you explain to us what's going on with that? Is money getting out the door to the providers? Is there a holdup? Am I mistaken, has that money gone out? Where are we?

COMMISSIONER KASTNER: We are very grateful for the Legislature, in the Executive Budget of last year, incorporating a 2 percent increase for direct support professionals on January 1st and also April 1st for this coming budget.

My understanding is that OPWDD has approved the new rate that would incorporate the increase for DSPs, but we're waiting to see that that is processed and then delivered

to the providers.

I don't know specifically where the holdup is, but I do know that we have approved those rates for providers for the January 1st increase.

SENATOR CARLUCCI: So but is it your understanding that that money has not been sent out the door yet?

COMMISSIONER KASTNER: From what the providers have told me, it has not yet arrived.

SENATOR CARLUCCI: Okay. So we need to --

COMMISSIONER KASTNER: We can look at where that is. It's somewhere between, obviously, OPWDD and our providers.

SENATOR CARLUCCI: Okay. Okay.

We've talked about it before, about what do we do to increase the longevity of our employees. And I've talked to you about the idea of a credentialing program, that we pay people for their experience.

Is there anything in the works through OPWDD to have a program where we are actually

paying people for their experience to make sure that that longevity continues? We have agreed in meetings that that longevity is paramount to the quality of care. It drives down the cases of neglect, of abuse, and just improves the continuum of care.

Can you tell us, is there anything in the budget that you can point to here, plans that OPWDD has to strengthen the workforce and to make sure that there's more of an incentive, that this is an actual career, a long-term career for people?

COMMISSIONER KASTNER: Well, Senator, as you know, when we met I told you that my first job in this field was in 1976 as a DSP.

SENATOR CARLUCCI: Yes.

COMMISSIONER KASTNER: So I understand the challenge of the work and the importance of the work. DSPs are the line staff, the individuals who have the most day-to-day contact with our individuals. So we value the DSPs. We have to find ways to create stability in that workforce and opportunities for professional development.

As far as salary, the last I was able to determine, looking at data from probably 2015, the average salary for DSPs in New York was about $13.65, which put us in the top five nationally. I think with the subsequent increases that have occurred, we're near $15 an hour, we're near the very top in terms of the rest of the country. And certainly we're favorably positioned relative to the states that we compete against -- Pennsylvania, New Jersey, New Jersey, Connecticut, Massachusetts, Vermont. We're certainly not losing workforce to those states.

We have tried to identify opportunities to leverage resources. We can -- we're conducting public service announcements in the North Country specifically reaching out to veterans at the time of separation from service, identifying a DSP role as a potential career path. We've been able to identify benefits that are available from the Department of Veterans Affairs that enhance salary and compensation. We've also identified that veterans are --

can benefit from enhanced entitlements like the SNAP Plus program.

We are working with academic institutions. We have two different groups working with the BOCES programs, one in Nassau and Suffolk Counties and the other upstate, to develop a curriculum and a certificate. I went to the graduation for DSPs on Long Island, it must have been in the fall, because that's an extremely important area for us.

We're also looking at credentialing, any number of activities that we can to elevate the quality of the work and the prestige associated with the role. It turns out it's not simply an issue of economics. I think people in the role value recognition and the credit for the work that they do. So working within both the state operations and our voluntaries to have a DSP Recognition Week and recognition events has been very important.

I've been to every part of this state celebrating DSPs and attending the

recognition events, which again we think is very important for setting a tone in how we value DSPs.

SENATOR CARLUCCI: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Assembly.

CHAIRWOMAN WEINSTEIN: We've been joined by Assemblywoman Kimberly Jean-Pierre and Assemblywoman Rosenthal, and go to Assemblywoman Gunther, chair of our Mental Health Committee, for questions.

ASSEMBLYWOMAN GUNTHER: Good morning. So I'm not going to ask you about the DSPs. We all know that we're looking for more money for retention for our DSPs, it's a group of women. So I know that you're working on that, and we're happy about that.

Thirteen dollars -- you know, McDonald's in the city just raised to $15. So, you know, there's a little competition here. And this is people's lives. So -- but I know that you're working on it, and I do appreciate it.

So my next issue is bed blockers --

that is, children who have aged out and should be in adult beds but continue to be an issue, they stay in children's beds. And you know that we have a place that I represent in Sullivan County that we have quite a few bed blockers, and there really is not very many places to move these folks to, and it is an issue.

So are we doing anything to create more adult beds in the DD community?

COMMISSIONER KASTNER: Well, as you will recall, in 2017 we received the support to build 459 new certified residential opportunities. We're about midway through that process in building new residential capacity. We also have $15 million in affordable housing capital available in this year's budget which will help us address that concern. And we also have the capacity to offer between 1200 and 1300 new residential opportunities each year.

So we recognize that is a problem. We're looking at how we can address that both in terms of the individuals who occupy those

beds, but also in making strategic investments in a continuum of care in order to reduce the pressure on those programs in terms of the numbers of children that are requesting residential services.

I'm sure I'll have an opportunity to touch on that in a bit.

ASSEMBLYWOMAN GUNTHER: Thank you. Now, managed care and the CCO issue is next. How can the Executive believe that moving to managed care will save the system money. It's just going to be another mouth to feed. When you theoretically take the same pot of money and add it to an entire another administration apparatus, what other conclusion can I and everybody else come to?

COMMISSIONER KASTNER: Well, as I think everyone within OPWDD has said, the move to managed care is not for the purposes of saving money. And as I described it earlier, we have a process in place where we don't have specific timing. The process begins --

ASSEMBLYWOMAN GUNTHER: Can you pull

the mic a little closer? Because I can't really hear you as clear as I should.

COMMISSIONER KASTNER: Sure. I have a problem with mumbling, and I have an FM radio voice --

ASSEMBLYWOMAN GUNTHER: So do I.

COMMISSIONER KASTNER: -- so I can put anybody to sleep.

(Laughter.)

COMMISSIONER KASTNER: But, you know, we're making investments to address the transition to managed care. The process right now is focusing on the CCOs and ensuring that all of our individuals have an appropriate care plan and also the policy framework being the SIPs-PL qualifications document, which is currently under revision. Those are the two steps that we're currently engaged in. We don't have time frames specifically for going forward.

ASSEMBLYWOMAN GUNTHER: Do you think managed care works in the DD system or will work in the DD system, it will save money or create better care? We should be -- the

focus should be on the quality of care, but it's all soft core so a lot of it has to do with money rather than quality.

And, you know, so far I don't think that there are many people that are bragging about managed care.

COMMISSIONER KASTNER: Well, as I said before, the focus on implementing managed care for people with developmental disabilities is not focused on saving money.

One of the facts I think that's not readily appreciated is that more than 28,000 people with intellectual and developmental disabilities have volunteered to enroll in mainstream managed care, and we believe that's largely because it provides better access to healthcare services for individuals -- services that in the fee-for-service Medicaid program might not be as accessible.

Generally that experience has been favorable. Individuals enroll on a voluntary basis; they can also disenroll on a voluntary basis. So we think managed care as a safety net for Medicaid State Plan services has been

very helpful.

As I said in regard to provider-led plans, we're still in the process of preparing the revised draft for public comment. We hope that that will be out shortly, and that will give us more insight into the feelings of our individuals and families as to whether or not we should pursue it and the timing and scope as we go forward.

ASSEMBLYWOMAN GUNTHER: So will services have to be cut for managed care and, you know, the uniqueness of the service that -- the services that you provide to those individuals?

You know, when I think about managed care, like, you know, you take in their age, there are different factors you take in. But in the DD community it seems like there's so many different things that could cost additional money because of the child or the adult themselves.

So managed care is we did it to save money. And I'm just wondering, you know,

what else will be cut. Right now we know that we're not paying DSPs, to me, enough money because we can see the turnover. And now we're on managed care, you know. And the hospital systems, I don't know that they got their big bang for the buck that they thought they were going to get, nor did they get the streamlined care that no infection or nothing unheard-of would happen, or something unexpected.

And I just sometimes wonder, with this unique community, how that's going to fit into it.

COMMISSIONER KASTNER: So the value proposition, if you will, in managed care is that managed-care organizations can avoid the need for unnecessary services. So by keeping people healthy, for example, they can reduce the amount of emergency room care or hospital care. And that premise is generally proven, I think, for all people who are Medicaid beneficiaries in virtually every state at this point.

ASSEMBLYWOMAN GUNTHER: I like the

fact that, you know, we do that in acute-care hospitals. And so on one side we're saying, yeah, better care, but on the other side we're saying we've got this turnover of DSPs. So one has to be worked out with the other in order to have any efficacy of these kind of changes.

And you know what, the investment over the years is getting better, but the investment in our most vulnerable populations, whether it's Mental Health or OPWDD -- you and I have been in those facilities, we've seen the people that work there, that are working at one facility on one end of the town and the other facility.

So I think that these ideas that, you know, that are thrown out -- thrown at us every X amount of years, they sound great. But, you know, have we seen a great deal of change in the acute-care facilities? A lot of readmissions, sometimes, but other than that I'm not really sure that it's been as effective as we think.

That's my last question.

COMMISSIONER KASTNER: Thank you.

ASSEMBLYWOMAN GUNTHER: I don't know if you have a comment on it.

COMMISSIONER KASTNER: Thanks.

CHAIRWOMAN KRUEGER: Okay. Senator Pete Harckham.

SENATOR HARCKHAM: Thank you, Madam Chair.

Thank you, Commissioner. Thank you and your staff for all you do. I want to thank the treatment providers and the family caregivers. You know, this population that doesn't have high-priced lobbyists, you know, doesn't have star-studded, you know, walkathons -- and so the people who are committed to this, you know, you're doing God's work and you deserve to be commended.

The question I have -- going back to your testimony, you talk about 15 million capital for housing. Many of us in our districts have existing housing, group homes or whatever, through various agencies that have been there a while. And what they need is new capital. They need reinvestment. You

know, they're at a point where they need new roofs, maybe new boilers, maybe new siding, whatever it is. And that's expensive.

Is reinvestment in existing properties part of this capital expenditure? Or is there money for that in other parts of your budget?

COMMISSIONER KASTNER: The reinvestment in capital for existing residential capacity is within the providers' budgets. These funds are for the expansion of new affordable housing.

SENATOR HARCKHAM: All right, so there -- you're -- I'm sorry, I didn't hear you. So you're saying that you're assuming there's capacity in providers' existing budgets to do capital?

COMMISSIONER KASTNER: I'd have to look specifically at how that is funded, but I believe that that is not within the scope of the $15 million that's within this year's budget.

SENATOR HARCKHAM: Okay. Is there any other funding, to your knowledge, anywhere in

your budget that will assist with capital for existing facilities to repair infrastructure -- new roofs, new boilers, those kind of things?

COMMISSIONER KASTNER: Yeah, I need to go back and ask our budget people that question. I apologize, I don't have the specific answer.

SENATOR HARCKHAM: Okay. No, that's fine. We can touch base afterwards.

COMMISSIONER KASTNER: Okay.

SENATOR HARCKHAM: All right, thank you.

COMMISSIONER KASTNER: Thank you.

(Pause.)

CHAIRWOMAN KRUEGER: Sorry. I'm so sorry. Thank you.

Next is Assemblymember Miller.

ASSEMBLYWOMAN MILLER: Hello.

COMMISSIONER KASTNER: Hi.

ASSEMBLYWOMAN MILLER: So as I'm sure you're familiar, I have way more questions than we are given time for. So I will focus on the issues, as usual, that I'm hearing

most concern about from the families that reach out to me from all over the state.

The first has already been spoken about a little bit: Our transition into full managed care. I know you've heard this before, even from me, but this model has not been successful in other states in this population. Why are we so insistent that it will be here?

I can tell you that currently there is little confidence on the part of the consumers who are stuck in this constant transition. Families and agencies were sold an amazing program -- care coordinators with graduate degrees who understood the needs of this community; they would be able to take so much off of our shoulders. We're certainly not seeing that. There is a tremendous turnover rate, much more so than before, I feel.

I myself, with Oliver, we're on our third care coordinator in a year. They're inexperienced in the actual coordinating that's required for this good care that we

were told was going to follow this. Many of them have been taken out of classrooms because at least they've dealt with this population, but unfortunately it doesn't mean that they know how to do what's required. This is not what we were told would be happening.

As I often say, you don't know what you don't know. And if the care coordinators don't know and the family doesn't know, guess what? The individual is not getting what they should be.

I'm sure you've heard all about the CDPAP program and that it's been a target, and now it's being looked at as one of the reasons that the Medicaid deficit is so great. And I realize that has nothing to do with OPWDD. But the bottom line, from your perspective, is that if these drastic cuts are made to CDPAP, there will be a much greater need for OPWDD services like residential placement in group homes, since these individuals will not be able to stay in their home care environments.

Currently it's allowing people to keep their loved ones at home. We know there aren't enough slots for residential placement right now, and I've heard you testify that you're increasing that. But what -- we really need to address this need for more housing, whether it be group home, supportive living, et cetera. This is coming.

There's also a rumor of cuts to the comm-hab staffing. This combination of CDPAP and comm-hab are what enable individuals to live successfully in supportive living or apartments. Removing these supports will be devastating -- and then what do you do with us? This is the most frequent question that I get from families: What are we going to do?

COMMISSIONER KASTNER: Well, as I described our planning for managed care, we have to be assured that the care coordination organizations are effective at delivering person-centered, conflict-free case management.

The CCOs launched July 1st of 2018.

When I arrived in January of last year, I believe it's fair to say they were well behind in their development of life plans for individuals. We specifically focused on that issue over the next year. I am pleased that as of the end of January, all individuals served through CCOs do have a life plan.

That only means they have a life plan. It doesn't mean that it is an adequate life plan, that it is person-centered or conflict-free.

ASSEMBLYWOMAN MILLER: Or that they have the services that they needed.

COMMISSIONER KASTNER: I certainly can give that to you.

But I will say that since July, when it became apparent that we would then be on-target for each individual having a life plan, we began weekly meetings with CCOs to focus on the more qualitative aspects of the plan -- you know, were they person-centered, did they provide services? We began looking at things like agency turnover and agency staffing.

We've had weekly meetings with CCOs. We're in the process of developing a performance report card based on metrics. We've told the CCOs that we plan to put information on our website to make it available for the public to see what percent of individuals who are enrolled have life plans and to look at their performance relative to each other --

ASSEMBLYWOMAN MILLER: Are you asking the families or the individuals or just the CCOs? Having a life plan is having a life plan. But are you asking the families are they getting what they need?

COMMISSIONER KASTNER: We're not serving the families specifically, we're talking with the CCOs at this point.

There is an opportunity to pull data off the life plans because they're now aggregated in an IT platform. But we certainly are open to looking at metrics that families may recommend as being important to them.

It's a process of evolution. But I

want to tell you, it's already underway and we plan on making that information available to people so that they can make an informed decision about the quality of care --

ASSEMBLYWOMAN MILLER: I think as usual the families are the last to be contacted, to be reached out to to see how is this working.

COMMISSIONER KASTNER: But we have revitalized, I think, the input from consumers both through our mandatory advisory committees and through other committees. We have numerous meetings with different parent advisory groups from around the state and also much more locally. We've really strived to improve our ability to work with families and communicate with them.

CHAIRWOMAN WEINSTEIN: Thank you.

We go to the Senate now.

CHAIRWOMAN KRUEGER: Senator Jim Seward.

SENATOR SEWARD: Thank you, Madam Chair.

And Dr. Kastner, thank you for being

here this morning -- or afternoon, I should say.

I wanted to continue the discussion a bit longer on the CCOs. And I just wanted to ask you directly, are there concerns that you're hearing from providers, families or other interested parties that are being brought to your attention through the -- you mentioned advisory groups and so on. But are you hearing concerns that you could share with us?

And also I would note that in last year's budget for fiscal year 2020, the enacted budget included $5 million to help providers with the transition to managed care. I note that that sum of money is not included in this year's Executive proposal. Is it no longer needed? Or is this something that should be continued? Why weren't these additional funds included in this year's Executive Budget?

COMMISSIONER KASTNER: To the second question, there was last year an appropriation of $5 million for provider

organizations to provide technical assistance to our community providers for the purposes of managed-care readiness. They've created a managed-care community of practice, are working with provider agencies on the potential transition to managed care.

I don't believe that there are funds in this year's budget. I can go back and look.

And if you can just repeat the first part of the question, I'd be happy to address that again.

SENATOR SEWARD: Well, I was just curious to hear whether or not you are getting any concerns from providers, families, and other interested parties in terms of how this rollout of the CCOs, how that's working. Do you have concerns directed to you?

COMMISSIONER KASTNER: Absolutely.

The CCO rollout was one of the most important issues that was presented to me in early February when I arrived. At that point the number of individuals receiving life

plans was far below what we expected, and we pushed the providers to meet time targets over the course of this year. So at this point every individual has a life plan.

Again, we're focusing on the quality of those life plans because we're still continuing to hear concerns from families and individuals as to whether or not those life plans are adequate.

SENATOR SEWARD: And how are you reacting to those concerns?

COMMISSIONER KASTNER: Well, as I said, there are carrots and sticks that we can use. And we meet with the providers and provide them technical assistance, looking at their benchmarks. But we've also told them we think this is important information to share with the public. Once we redesign our website, we will be creating a place on the website for people to look at CCO performance and judge for themselves how well they're doing. We think that that type of public disclosure is really to the benefit of our individuals and families and should drive

performance.

SENATOR SEWARD: Okay, thank you.

Just one final question. I wanted to shift gears to the issue of can you share with us some of the latest developments on the sheltered workshop transitions to integrated work settings as well as intermediate care facilities' conversions and the other Home and Community Based Waiver-related compliance actions?

Specifically on the -- transitioning our sheltered workshops, one concern that I have when I tour the workshops in my district, many of these folks would like to continue to be working there. That's what they know, that's what they want. And is this going to continue to be possible? If you could just give us an update on how that's going.

COMMISSIONER KASTNER: Sure. As you know, we are transitioning from sheltered workshops to employment, competitive employment and supported employment. As of last year, I believe, there were about

30 agencies that were operating sheltered workshops. More than half of them had successfully completed a transition to some form of employment or supported employment. I don't have more specific data than that, but I can obtain that. I can provide it to you at a later time, if that would be okay.

SENATOR SEWARD: Thank you.

CHAIRWOMAN WEINSTEIN: We go now to Assemblywoman Rosenthal.

ASSEMBLYWOMAN ROSENTHAL: Thank you.

OPWDD transitioned from about 350 Medicaid service coordinating organizations to seven care coordination organizations to try to eliminate conflicts in the case management system. Do you know if providers are able to open their own CCOs and recommend the individual receive services through that provider?

COMMISSIONER KASTNER: You are correct that one of the goals of the CCO implementation was to create a system that was conflict-free. We collaborated with the Department of Health to implement CCOs using

the health home model. The Department of Health is the primary regulator of CCOs.

We also coordinated with CMS about the design of CCOs and the role of providers in helping to create CCOs. We believe that that satisfied CMS in terms of the requirement to be conflict-free.

ASSEMBLYWOMAN ROSENTHAL: I mean it's just about a year old, right, or less than a year old?

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

ASSEMBLYWOMAN ROSENTHAL: This has just been in place for a short time. But have you heard back from individuals or their families in terms of how satisfied they are with the services?

COMMISSIONER KASTNER: I believe that generally satisfaction is one of the metrics that we're looking at. I don't have that data offhand. But we are talking with families and individuals about their satisfaction. And obviously there are opportunities for improvement in that regard.

ASSEMBLYWOMAN ROSENTHAL: Do you believe a managed care company paying a capitated rate will lead to higher-needs individuals receiving less care?

COMMISSIONER KASTNER: Well, as I described it, we have a process for the implementation of managed care. We're at the beginning of that process. We're just now revising the draft SIP-PL document.

Managed care implementation will depend upon, I think, the feedback that we get on that document. There are many ways in which managed-care implementation could occur. It could be focused on state plan services versus waiver services, it could be focused on certain types of beneficiaries -- for example, people with Medicaid, people who are dually eligible through Medicaid and Medicare, people with medical insurance. It could be phased in in different geographies.

There are many inputs to an answer that we're really not prepared to offer at this point.

ASSEMBLYWOMAN ROSENTHAL: And when do

you think you will be?

COMMISSIONER KASTNER: Well, again, the process is to publish the revised draft SIP-PL qualifications document, ask for the public input, and see what they think of the revisions that we will be making.

ASSEMBLYWOMAN ROSENTHAL: Okay, thank you.

CHAIRWOMAN WEINSTEIN: We go to Senator Savino for questions.

SENATOR SAVINO: Thank you, Assemblywoman.

Commissioner, this question may have been asked previously when I was out of the room, I apologize. But I did say that I would ask on behalf of the affected individuals. I do want to, though, echo the comments of many of my colleagues with respect to housing issues. This week it's -- I think we're going to be having the Developmental Disabilities Breakfast in Staten Island, and there will be another one in Brooklyn, and it is the number-one issue that comes up over and over as aging parents

are more and more concerned about what will happen to their sons and daughters if they're not around. So we've got to solve this housing crisis.

Again, I believe it's the shame of this state the way we treat human service workers, particularly direct support professionals. That they're equated with minimum wage work, it's just -- it's outrageous. But it is what it is.

Last year, in an effort to satisfy the #bFair2DirectCare campaign, where the Governor proposed -- and it was adopted -- another deferral of the COLA, the human service COLA, we did commit to an additional 2 percent to the agencies. I'm being told by several of the agencies in my district that they're not collecting that money yet. In fact, they won't -- they anticipate they won't get it till after this budget is put to bed.

Can you tell me what's happening with the #bFair2DirectCare money and why it hasn't been disbursed?

COMMISSIONER KASTNER: Certainly. We've been discussing -- the January 1st increase of 2 percent for DSPs was recommended by OPWDD. It was incorporated into our rates, and then the rates are sent up for approval and loading.

So you are correct, they have not yet been received by our providers, but we do expect they should be received in the near future. I can't speak as to whether or not that might occur after April 1st or not. But we're committed to ensuring that those rates go into force and that they are retroactively paid back to January 1st.

SENATOR SAVINO: I'm not understanding why, if it was supposed to go into effect January 1st, why didn't it?

COMMISSIONER KASTNER: As I said, they've been approved by OPWDD --

SENATOR SAVINO: They've been approved, but they haven't been disbursed.

COMMISSIONER KASTNER: Correct. Because we're not the sole entity responsible for payment to providers.

SENATOR SAVINO: Would the other entity be Medicaid?

COMMISSIONER KASTNER: Well, these are Medicaid funds; it involves the Department of Health, the Division of the Budget.

But I can tell you at our end we have approved those rates and recommended that they be paid. They will be paid retroactive to January 1st.

SENATOR SAVINO: Will they receive interest?

COMMISSIONER KASTNER: I can't speak to whether or not that occurs. I --

SENATOR SAVINO: It's almost as if we're -- you know, they're giving you guys an interest-free loan. And I'm not putting you on the spot, it's just -- you know, people worked very hard to get that increase, and it's just a little disconcerting to see that while it's in statute, it's not actually in operation. And these agencies operate on the margins so often, as you know. And so it just presents even more complications for them as they deal with, you know, their own

issues.

So I would hope we would find a way to do it faster. And I really do think we might want to consider giving them the interest on the money that they're owed.

COMMISSIONER KASTNER: We can certainly go back and try to nudge that process forward as quickly as we can. I understand it's a cash-flow concern for providers. I ran provider agencies --

SENATOR SAVINO: Yeah.

COMMISSIONER KASTNER: -- myself, and I understand the margins are tight, that cash flow is a problem.

SENATOR SAVINO: And again, not to put you on the spot, but on January 1st the minimum wage went up in this state. And so part of this money was to help them meet that. And so they're saddled with paying the higher wage to their workforce, God bless them -- in fact we want people to earn a better living -- but they didn't get the money to help them do that.

So I just think we should be a little

bit more aggressive about making sure they get their money.

COMMISSIONER KASTNER: Well, thank you. As I said, I'll go look at that.

SENATOR SAVINO: Thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

We go to Assemblywoman Miller.

ASSEMBLYWOMAN MILLER: I have just two other things that I wanted to ask. I'm hearing a lot about individuals on self-direction not having -- or the rumor that they will not have full budget authority. And it's frightening to hear that.

Consumers have rights. Self-direction allows individuals to integrate into the community. They're gaining skills, making progress to be more independent, with the assistance of the comm-hab staff that I was telling you before.

Isn't this the vision and mission statement of OPWDD? And I quote: "Vision Statement. People with developmental disabilities enjoy meaningful relationships

with friends, family and others in their lives, experience personal health and growth, and live in the home of their choice and fully participate in their communities."

The mission statement. We help people with developmental disabilities live richer lives. Isn't that the promise that we're making to these constituents? I know it's what I promised.

They want to know what happened to choices. Taking away the full budget authority within the regulations and guidelines from the families and the brokers will be devastating for them.

The other -- wait, before -- I'll just ask them both at once and then you can just answer.

Two years ago we enacted legislation that created a new training program for first responders to recognize and use appropriate techniques to handle emergency situations involving individuals on the autism spectrum disorder. What's the status of that? And has anything been developed, has anything

been implemented as of yet?

COMMISSIONER KASTNER: Sure. Self-direction is an important tool for us in helping families and individuals access the services that they need. Last year alone, we expanded the Self-Direction Program, added 3500 more individuals and their families to the program, at a cost of approximately $100 million.

So we are committed to self-direction. We currently spend about $400 million a year and support 17,000, 18,000 individuals. We're -- we're not talking about cutting it. We're not talking about the loss of budget authority.

ASSEMBLYWOMAN MILLER: You're just giving the control to the CCMs {sic}, to the care coordination agencies, rather than the families and their brokers?

COMMISSIONER KASTNER: I -- I don't --

ASSEMBLYWOMAN MILLER: The CCOs are already overwhelmed with the tasks that they have.

COMMISSIONER KASTNER: Well, CCOs are

responsible for developing a life plan. That is separate from a family working with a fiscal intermediary or a support broker to develop a plan of services to be delivered through self-direction.

ASSEMBLYWOMAN MILLER: But the actual control over the self-direction budget -- things change. It's fluid. It changes back and forth. Where you don't use one thing, we put it into another -- like we have the ability to make it meet the needs of the individual.

COMMISSIONER KASTNER: So families have full budget authority, and they execute that with --

ASSEMBLYWOMAN MILLER: And they're not losing that.

COMMISSIONER KASTNER: We have no plans at the current -- at this current time to eliminate self-direction or full budget authority.

ASSEMBLYWOMAN MILLER: Okay. Because that was one thing that I keep hearing, that they're taking the control and removing it

from the families.

Okay, thank you. And then the --

CHAIRWOMAN WEINSTEIN: Thank you.

ASSEMBLYWOMAN MILLER: Thank you.

CHAIRWOMAN KRUEGER: Senator Carlucci for a second round.

SENATOR CARLUCCI: Thank you.

Commissioner, I know we've been asked about the funding not coming through the door yet. We've also heard that the July 2019 rates have not been approved either. Is that true?

COMMISSIONER KASTNER: To your point, the July 2019 rates were approved by OPWDD. And similar to the January 1, 2020, rates, they were presented, they need to be approved and loaded and then paid. We recognize that that's a hardship for our providers, and that does affect their cash flow. And we're working as effectively as we can to try to get those funds made available to our providers.

SENATOR CARLUCCI: Okay. And we're also hearing that there will be a cut across

the board in July of this year. Can you tell us about that? Do you know how much that cut will be? And is that -- is that true?

COMMISSIONER KASTNER: The budget did include a 2 percent across-the-board cut for providers, that is true.

SENATOR CARLUCCI: Okay, so 2 percent across the board.

And before, in the previous conversation we had or testimony we had, we talked about how 80 percent of the services being provided by nonprofits, 20 percent by state-run facilities. Can you tell us about the cost of living adjustment or the trend that we've seen? Is that provided equally to state-run facilities as well as non-for-profit facilities or operations?

COMMISSIONER KASTNER: Well, we've talked a lot about the rates paid to voluntaries for the services provided on behalf of people with developmental disabilities.

The state side of the operation is funded based upon the collective bargaining

agreement. So I would defer to that document and those negotiations for specific information about the size of any increases of salary or benefits.

SENATOR CARLUCCI: So are we saying there's a difference between the COLA for state and the COLA for nonprofit organizations?

COMMISSIONER KASTNER: There probably is. I don't know the specific nature of that, but that would be a reasonable assumption.

SENATOR CARLUCCI: Well, it seems that there's been a deferred COLA on the nonprofits but not for the state.

COMMISSIONER KASTNER: I'm sorry?

SENATOR CARLUCCI: The COLA has been deferred for the nonprofits but not for the state-run operations.

COMMISSIONER KASTNER: Well, as I said, there is a deferral of the COLA for the voluntaries. I don't know what the specific parameters are of increases for state employees under the collective bargaining

agreement.

SENATOR CARLUCCI: Okay. I wanted to ask just -- this has come up. We see in the Executive proposal that the -- there will be the removal of the background checks for health homes in the Executive Budget. And you're talking about it's a duplication of a background check.

Could you tell us more about that and maybe tell us why that's necessary and what that will do?

COMMISSIONER KASTNER: That is applicable to health homes in general. The health homes are operated by the Department of Health. That falls outside of OPWDD's scope, so I really can't comment on that.

SENATOR CARLUCCI: Okay. Since I have just a minute left, I wanted to ask about when we talk about children with autism, we see a large spectrum. And I've been working with parents particularly that are concerned about high-functioning children with autism and making sure that they have the appropriate services.

Can you tell me what OPWDD is doing to make sure that children with high-functioning autism are getting the services that they need?

COMMISSIONER KASTNER: Sure. One of the strengths of OPWDD is that it's focused on individuals and the planning is individualized. And if you qualify for OPWDD services, you actually access a wide range of support and services. There are many children, particularly individuals with high-functioning autism, who can benefit from services but may not qualify.

And in addition, we historically have not been particularly strong at building systems of care. So we're taking a lesson, I think, from OMH and focusing on building a continuum of services. We're looking at how to engage pediatric providers, primary care providers, and other healthcare professionals to provide appropriate supports. We're looking at building capacity among behavioral health providers. We're also trying to expand our access to intensive behavioral

services and, as I described in my testimony, building out our network of crisis response services.

We think there's a significant opportunity to help children and their families in particular access services which might be more preventive in nature, as opposed to reactive. I've heard the comments about individuals in ERs and hospitals. We want to try to avoid those when we can. So being proactive, building systems that support individuals would be very helpful in that regard.

SENATOR CARLUCCI: Thank you, Commissioner.

CHAIRWOMAN WEINSTEIN: Thank you.

We go to Assemblywoman Griffin.

ASSEMBLYWOMAN GRIFFIN: Thank you.

Good afternoon. I don't know if this has been asked before, so forgive me if I'm repeating. I know that the direct care worker wages have increased by 4 percent, and a 2 percent increase for clinical staff. But I often meet with groups that work within

these groups, but they're not considered direct care workers so they might not be getting this wage increase.

And I wondered, are there known groups that are excluded from being categorized as direct care workers?

COMMISSIONER KASTNER: My understanding of how the salary increases for DSPs occurs is that there are certain types of positions that are eligible for that increase and others that are not. I mean, clearly the focus is on supporting individuals that have a direct care relationship to individuals as opposed to management in the nonprofits.

So we use certain position categories to identify individuals that would be eligible for that salary increase.

ASSEMBLYWOMAN GRIFFIN: Okay, thank you. Yeah, it seems like there are -- you know, I've met with -- I represent southwestern Nassau County and I've been at a couple of, you know, information meetings, legislative breakfasts. And obviously it's a

very underfunded area. And there's so many workers that -- you know, so many families can't find people to work with their loved ones because it's not well funded, like to give them the adequate salaries. So it does seem to, you know, to be an issue. So that is something that I do question.

The other thing is I notice that we have a cost-of-living adjustment that has been deferred. So if the direct care workers are getting an increase, who are the ones that getting deferred from a cost of living adjustment?

COMMISSIONER KASTNER: The salary increases that were described earlier, the January 1st and April 1st, are for DSPs. The second increase is for DSPs plus clinical staff. So the intent is to support the capacity of organizations to provide services directly to the individual, but the salary increases are not focused on management.

ASSEMBLYWOMAN GRIFFIN: Okay. Okay, thank you very much.

CHAIRWOMAN WEINSTEIN: Senate?

CHAIRWOMAN KRUEGER: Thank you. I'm almost going to let you go. So someone asked you before, but either I didn't understand the answer or you didn't give the answer.

You have 150 agencies on a financial watch list. Tell me what that means, give us a list of the agencies -- send it to us -- and tell me what it means when you add a 2 percent cut in July.

COMMISSIONER KASTNER: As we discussed, we are looking at our provider capacity to ensure that it is adequate to meet the needs of our individuals. The current payment methodology to providers is based on cost-based -- is cost-based, meaning that the agencies send us a consolidated fiscal report which identifies all of their costs. All of those costs go into the rate setting for that specific organization.

So there's a high degree of variability for each agency in terms of the rate that they're paid. We look at agencies that may be fiscally stressed. We do not want agencies to fail. We're particularly

concerned about agencies that have lower costs, because they receive lower compensation. Those are agencies that we do want to support. There's no incentive for us to allow them to fail, because if they fail generally a higher-cost agency would assume responsibility for providing those services.

So we're looking at opportunities to try to enhance their operations and make them viable.

CHAIRWOMAN KRUEGER: So you will be able to provide us with a list of the 150 that are now on the watch list?

COMMISSIONER KASTNER: Of course.

CHAIRWOMAN KRUEGER: How many of them went under last year?

COMMISSIONER KASTNER: I do not know.

CHAIRWOMAN KRUEGER: You don't know?

COMMISSIONER KASTNER: No, I don't have that personal information. We can find that for you.

CHAIRWOMAN KRUEGER: So if you could follow up and also let us know how many went under in the past 12 months.

COMMISSIONER KASTNER: Yes. Yes.

CHAIRWOMAN KRUEGER: I think that's your time with us today. Thank you very much for testifying.

COMMISSIONER KASTNER: Thank you, Senator.

CHAIRWOMAN KRUEGER: Thank you. And our next government witness, New York State Office of Alcoholism and Substance Abuse Services, Arlene Gonzalez-Sanchez, commissioner.

Good afternoon.

COMMISSIONER GONZALEZ-SANCHEZ: Good afternoon, Senator Krueger, Assemblymember Weinstein, Senator Harckham, Assemblymember Rosenthal, and distinguished members of the Senate and Assembly. My name is Arlene Gonzalez-Sanchez, and I'm the commissioner of the New York State Office of Addiction Services and Supports, or better known as OASAS.

Thank you for providing me with the opportunity to present Governor Cuomo's fiscal year 2021 Executive Budget as it

pertains to OASAS. The Governor's Executive Budget proposes that OASAS receive over $821 million, including $140 million for state operations, $90 million for capital projects, and $591 million for aids to localities.

The proposed Executive Budget will enable us to continue funding our prevention, treatment and recovery programs, including the increase in minimum wage for OASAS-funded providers as well as targeted salary increases for support, direct care and clinical staff.

The budget also supports increased spending for capital projects consistent with the agency's five-year capital plan, including over 200 residential treatment beds expected to open throughout the state over the next three years.

The Executive Budget establishes a new fund for the collection of fines levied for violations of existing state and federal behavioral health parity laws. Monies from this fund would be used for initiatives supporting further parity implementation,

including the ombudsman program.

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

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

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

services.

Counties served by COTIs have seen a 25 percent decline in opioid-related overdose deaths and a 48 percent decline in opioid overdose emergency department visits. So this year we're expanding COTIs statewide. Today we announced the availability of funding to establish one mobile treatment vehicle in each of the 10 Economic Development Regions in New York, and to develop telepractice capacity in every county in the state.

We have also facilitated collaborations between emergency departments and OASAS-certified treatment programs to enhance medical providers' ability to offer MAT. EDs can begin induction on medication to treat opioid use disorder, and with the help of peers, provide a supportive transition to ongoing treatment.

Another area that I would like to highlight is our efforts to establish and support MAT in state and local correctional facilities. Currently MAT is offered in

11 state facilities and 52 county correctional systems, including New York City.

We are currently working with the New York State Department of Corrections and Community Supervision and the Department of Health to implement a buprenorphine program. Medical staff at the seven facilities have received training on buprenorphine already. This will permit individuals who are maintained on buprenorphine while incarcerated in county jails to continue their treatment when transferred to state custody.

OASAS also working closely with DOCCS to initiate an OTP inside a correctional facility. This would be the first state-operated OTP in a correctional facility in the country.

As we all know, recovery supports are crucial. Over the past year, we have opened 18 new recovery centers, for a total of 32 recovery centers serving more than 50,000 individuals across the state. The

agency has also implemented a multifaceted approach to prevention, reaching youth, families and communities across the state through classroom-based curriculums, schoolwide environmental activities, and individualized prevention support for at-risk students.

All of these services would not be possible without a dedicated SUD workforce. At OASAS we are proactively finding ways to support employees and staff. Last week we announced the award of over $300,000 in scholarship funding to support the professional development of employees at OASAS-certified organizations.

Finally, we continue developing public education campaigns to address stigma, raise community awareness about addiction, and provide information on where to get help. In 2020 plans are underway to launch new campaigns to address many common misconceptions about addiction prevention, treatment and recovery.

So as you can see, we have been

working on expanding and enhancing our services across New York State. And under Governor Cuomo's leadership, and with your support, we continue to make an aggressive push to confront the opioid crisis and save lives. We look forward to your continued partnership as we advance these priorities.

Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Senator Pete Harckham.

SENATOR HARCKHAM: Thank you, Madam Chair.

Commissioner, it's great to see you. Thank you and your team for the great work that you do.

Before I ask you a couple of questions, just a statement -- and you don't have to respond to this -- that many of us and many of the people in the field think that you are drastically underfunded. And so I know that's not a question; you don't have to respond to it. Those decisions are made at a different pay grade. And I'm sure you'll hear testimony from some of the

experts later on in the afternoon saying the same thing.

So I just wanted to put out on the record that for this Senator and for a number of the Senators who could not be here, we need to see your funding increased drastically, and that's our job to do. So thank you for all you do.

A couple of things. We spoke about workforce issues with the other agencies. The Senate was happy to partner with you on the loan forgiveness, $300,000. Tell us how that program is working, how it's been received, and should we expand that.

COMMISSIONER GONZALEZ-SANCHEZ: It's going tremendously well. As a matter of fact, last week we announced -- I think it was like 38 or 48 awards, which tells you that it's really very much needed. People really jumped on it. With this money, people who are already or are thinking of becoming licensed social workers or mental health professionals will get additional help to pay for the schooling as well as the certified

prevention.

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

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

COMMISSIONER GONZALEZ-SANCHEZ: Well, as Commissioner Sullivan indicated, they've served over 1600 cases already. It's boots on the ground. There are five community agencies right now that are funded through the 1.5 that are actually doing the boots on the ground helping individuals.

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

of the state that we don't have a community-based organization to assist families.

SENATOR HARCKHAM: Right.

COMMISSIONER GONZALEZ-SANCHEZ: And I see you have the map.

SENATOR HARCKHAM: Yeah.

COMMISSIONER GONZALEZ-SANCHEZ: And so if we were to acquire additional dollars, we would want to ensure that those areas that are blanked, we could have a community-based organization there to help individuals work with these entitlement issues.

SENATOR HARCKHAM: All right. So this is the map of the areas where we have gaps. So the gray areas are where we have gaps, the colored are the regions where we have service.

So how much would it cost us to get to fill in the entire state and cover all the regions?

COMMISSIONER GONZALEZ-SANCHEZ: So right now we're funding the existing ones at $30,000, and there are five of them. What we

understand is that the funding is a little low, so what we'd like to do is bring it up to $50,000 and then fund additional CBOs at that rate.

SENATOR HARCKHAM: Okay. And then the thought, as explained to me, is that the ombudsman program would go to $3 million, with approximately $1.5 million coming from the new ability of OFS to levy fines -- promulgate rules and levy fines against insurance providers who are not guaranteeing parity.

COMMISSIONER GONZALEZ-SANCHEZ: Yes, it would be up to 1.5 if the appropriation is approved and goes through.

SENATOR HARCKHAM: Okay. All right.

And then in your estimation -- let's just say things work in a perfect world, that part of the budget goes through. How long do you think it takes for OFS to promulgate the rules, people get up to speed, cases brought, fines developed, and money starts flowing in?

COMMISSIONER GONZALEZ-SANCHEZ: Well, like anything, it will probably take a little

time to get off the ground. So in the interim, you know, we'll have to continue working in the areas that we are. But it may take a little while before fines are promulgated and collected.

SENATOR HARCKHAM: So we're still going to be short -- unless there's legislative action, we're still going to be 1.5 shy from the 3.0.

COMMISSIONER GONZALEZ-SANCHEZ: Yes.

But, you know, I also want to make clear just because we don't have a community-based organization in those areas, that we are not intervening when we're called upon. It's just that it makes it more difficult when you don't have, you know, CBOs in particular areas. But we will continue --

SENATOR HARCKHAM: Right. And you've got -- you've got the hotline, but that's still not a 24/7. So in either case, we have gaps that we need to fill.

COMMISSIONER GONZALEZ-SANCHEZ: Yes.

SENATOR HARCKHAM: Okay. Okay.

Moving on, a couple of other quick

things. We did a lot of traveling around the state, as you know, the Senate did, in the summer and in the fall, and we found out that there were a lot of gaps. Gaps when people leave hospitals, when they leave a correctional facility, when they leave treatment.

And one of the things that the federal government has offered is funding of take-home doses, up to a month. And that can help sort of fill the gap in medication-assisted treatment while we're trying to get someone into their next.

New York's Medicaid reimbursement model disincentives this. So what are we doing to try and make this a more proactive means of protecting people in the short term?

COMMISSIONER GONZALEZ-SANCHEZ: So as you know, it is a complicated system, and some of it is outside the jurisdiction of OASAS. Nevertheless, we continue to work with correctional facilities, with our community-based organizations, to see how we could minimize those risks of people being

released without medication, using our peers and primarily our community-based, you know, providers who assist us in being there and helping us with this situation.

But it is a complicated system that really falls outside of, you know, OASAS when you're talking about Medicaid.

SENATOR HARCKHAM: Okay. All right. I know we're going to run out of time soon. I'm going to try and combine a bunch of questions into one.

Criminal justice. You had mentioned medication-assisted treatment in our correctional facilities. A, want to know how that is going.

B, we talk about criminal justice reform. A lot of the sheriffs are saying, Well, we no longer have that population to treat. Obviously that's not where we want to treat people, we want to get them first.

But what are the things that we can do at the time of prearrest or arrest rather than, you know, for that lower level population?

And the third question is, what are we doing to aid folks when they're getting out of correctional facilities as a bridge? Because we know that's -- those are among the highest population for overdose deaths.

COMMISSIONER GONZALEZ-SANCHEZ: Okay, so let's see how I figure this out. So let's start off with we have 56 community-based correctional facilities. And out of the 56, 45 are doing Vivitrol and 32 are doing methadone and buprenorphine.

Now, on the state correctional side, we have 52 prisons. All 52 are doing some addiction services. Out of those 52, 11 are doing medication-assisted treatment. Out of those, four are doing Vivitrol and seven are doing methadone. And soon, hopefully soon they'll be doing buprenorphine as well.

So we have currently over 200 individuals behind the wall in state facilities, including a handful of pregnant women that are getting medication-assisted treatment behind the wall.

On the community side, as I indicated,

we have those programs already providing medication-assisted treatment. For those, we continue to work with the sheriffs to look at realigning some of the dollars that they got to prescribe medication -- because the time frame is so short now, to do more quick assessment and referrals using peers.

We're also working with the various DAs, you know, in Staten Island, here in Albany, to do diversion programs at the point in which police interact with the individual prior to arraignment -- the HOPE program in Staten Island, LEAD here.

So we are doing a lot of different things on the community side to really address this issue.

SENATOR HARCKHAM: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Assembly.

CHAIRWOMAN WEINSTEIN: We go to Assemblywoman Rosenthal, chair of our Alcoholism Committee.

ASSEMBLYWOMAN ROSENTHAL: Hi. Thank you. Hello, Commissioner. Good to see you.

So we've heard how overdose deaths are going down. But can you explain the disparity in data between the DOH opioid dashboard and the DOH county opioid quarterly reports? And from the dashboard, it doesn't appear to be any improvements in opioid-related deaths in the state, yet it's been said often that the number of opioid-related deaths seems to be going down.

COMMISSIONER GONZALEZ-SANCHEZ: I don't know that I'm prepared to discuss DOH dashboard data. I don't know that I really could do that. So I couldn't respond to that.

ASSEMBLYWOMAN ROSENTHAL: Okay. So assuming, yes, there's a reduction in overdose death rates between 2017 and 2018 -- and I think a lot of them were in the City of New York -- the pace of recovery is lopsided. And we've not moved the dial for low-income communities and communities of color, it seems.

I have legislation to require that naloxone be made available in homeless

shelters across the state, because every life matters. Does OASAS have a program to provide shelters with naloxone?

COMMISSIONER GONZALEZ-SANCHEZ: Well, as you know, we do provide training, naloxone training, and we do our own training. We also, in collaboration with DOH, do that. And when we do train folks, we have the ability to give kits.

ASSEMBLYWOMAN ROSENTHAL: But I don't believe that it's a requirement in all the homeless shelters. And certainly people with opioid use disorder are present in shelters the way they are throughout society.

COMMISSIONER GONZALEZ-SANCHEZ: Right. I don't believe it's required that they do that. But I do know in some of the shelters that we have both mental health and addiction teams doing some work with individuals in the shelter. I believe there's an offer and -- to give kits and also to train individuals, to engage them in treatment.

But in terms specifically of Narcan kits being given out, I really couldn't tell

you that that was a mandate, no.

ASSEMBLYWOMAN ROSENTHAL: Okay. So along those lines, I'm the sponsor of legislation requiring that medication-assisted treatment be provided in state and county correctional facilities as well as, yes, state prisons.

The Governor announced in a State of the State proposal that New York would seek to have DOCCS recognized as an OTP. So while it's good that the administration is recognizing the importance of targeting the vulnerable population with offers of MAT, getting it recognized as an OTP will take a long time.

It would be great if the administration would consider expanding its relationship with community-based OTPs so the state correctional facilities can start providing access to MAT now.

COMMISSIONER GONZALEZ-SANCHEZ: Well, in fact there are some guest dosing that was being done by our community-based organizations at these different facilities.

And when DOCCS does get a program, then they'll be able to do it on their own. But for now it's through relationships with our community-based organizations that they are providing the methadone.

ASSEMBLYWOMAN ROSENTHAL: I don't understand how anyone could justify not providing buprenorphine, Vivitrol and methadone -- all three -- in state prisons where we know it's needed. Every single prison, so that -- and in every county facility as well. Because we know that overdoses happen, we know that people sometimes struggle to not be as dependent.

So if they had the buprenorphine, if they had methadone, if they had Vivitrol for those who want the one-month shot, that that be given to them. I mean, they don't have fewer rights in terms of healthcare just because they're behind bars.

COMMISSIONER GONZALEZ-SANCHEZ: So what I'd like to say -- first of all, you know, I feel that I'm answering for the DOCCS commissioner, and I want to make sure that I

don't do that. But from where I sit, I have to say that I've seen a tremendous partnership with DOCCS in the last couple of years. I mean, the fact that we are in 11 facilities I think speaks a lot.

I think we need to also learn a little more about the needs behind the wall: Do we need 52 prisons to have all three medications? I don't know. And I think this is something we have to evaluate.

You have three reception centers that they are opening that, you know, individuals, once they are arrested and before they get transferred to wherever they're going to do their state time, will go. We have three that they could continue their medication, and now we have seven facilities.

I think we need to look at who we're talking about. Are the numbers there to then say we need to expand it to yet more prisons? And I humbly say that's my opinion, and I don't want to speak for the commissioner of DOCCS.

ASSEMBLYWOMAN ROSENTHAL: Okay. Well,

the Assembly last year added $1 million to the budget to expand MAT, but this funding was not carried over into the 2021 budget. So are there concerns that the funding, you know, not being continued will affect the pilot programs that are going on?

COMMISSIONER GONZALEZ-SANCHEZ: Well, I have to say that yes, it wasn't carried on. It was a one-time item, so the expectation was not to carry it on.

However, I think that there are efficiencies that we could look at. Like I said, that we are looking, we are working with the local sheriffs and police to see how we could realign some of the dollars that are in the county jails.

And so at this point I think that there are concerns. I think that people are working more closely together because of other changes in laws. And we're watching it carefully to see if they are.

ASSEMBLYWOMAN ROSENTHAL: I think this is part of a game. Like you put it in the budget, and I'll take it out, and then you

restore it.

But in this area, and I'll echo Senator Harckham said, there's no room for games here. I mean, it's a small budget and the need is so great. We need to have Narcan in every emergency room. We need buprenorphine in every emergency room. We need MAT available with counseling to people behind bars. We need so much more. And this petty -- you know, the Executive removes 2 million for SAPAS workers, the Assembly restores it, now the Senate can join us in restoring it. It's like games that shouldn't happen in a budget that is dealing with life-and-death issues.

And I wish that there was much more money devoted to dealing with the overdose crisis than there is right now.

Can you tell me how much federal money OASAS has received this year?

COMMISSIONER GONZALEZ-SANCHEZ: Well, we receive 111 million from -- for prevention and treatment. And as part of the SOR, we are receiving 35, I believe -- 32, 35

million.

ASSEMBLYWOMAN ROSENTHAL: And do we know what we expect in the future?

COMMISSIONER GONZALEZ-SANCHEZ: The SOR, the state -- well, the federal grant, we expect the same amount unless there are some cuts in Washington. The SOR is time-limited, so this will be the last year that we get the 30 to 35 million that we're getting.

ASSEMBLYWOMAN ROSENTHAL: Okay. And then I see time is running out, but I have legislation on sober homes, three-quarter homes, recovery homes, where people who are newly in recovery go to find a supportive environment in which to live.

But many in recovery homes are in treatment looking for a stable living environment. Sober homes are not typical housing, and they are not treatment, so they fall within a gray area. Someone who doesn't have a safe and stable home in which to live will find it much more difficult to maintain their sobriety.

What does OASAS think its role is, or

should be, with respect to sober homes?

CHAIRWOMAN WEINSTEIN: And you'll have an opportunity to answer that in the second round.

ASSEMBLYWOMAN ROSENTHAL: Okay.

CHAIRWOMAN KRUEGER: Thank you.

Senator James Seward.

SENATOR SEWARD: Thank you, Madam Chair. And thank you, Commissioner.

Following up on the discussion in terms of what goes on in the local jails, I know that the last two to three years this has been a Senate priority, to include $3.75 million for jail-based substance use disorder treatment. Have these funds been released from this year's budget? Or what's your plan to implement this $3.75 million?

COMMISSIONER GONZALEZ-SANCHEZ: Oh, no, the 3.75 is in the base. And yes, it's been released. And that's what the local jails and sheriffs are using to develop peer programs and so on and so forth. It's very well used, yes.

SENATOR SEWARD: Do you have a process

in place to evaluate the effectiveness of these programs?

COMMISSIONER GONZALEZ-SANCHEZ: Of the jail-specific ones?

SENATOR SEWARD: Right. Right.

COMMISSIONER GONZALEZ-SANCHEZ: We have a process and -- we have a report that we actually share with the Legislature on all the new initiatives, like the recovery supports, the clubhouses. And I believe the report was sent either last week or today or something -- I think last week.

With respect to the efficiencies or the -- not efficiencies, but the outcomes of the jail-based, we're continuing to work with the sheriff associations to monitor the outcomes. So we work with them. Do we get a report? We're working on trying to get a report from them.

SENATOR SEWARD: I would share the concerns of my colleagues that the additional $1 million for the MAT program in our local jails is not included in the Executive's proposal. And it's certainly, I think, a

much-needed program that hopefully we can figure out a way to continue that.

You mention the reduction in heroin overdoses here, and I've experienced that in some of my counties as well. Would you say that this is -- this phenomenon, and I think it is a good trend to see. But is there a way to evaluate whether that is because of the expanded availability of Narcan? Or is there just less use of heroin through, you know, the treatment opportunities and the like?

I mean, how can we judge whether it's the Narcan or less use through treatment and other means?

COMMISSIONER GONZALEZ-SANCHEZ: I think it's a combination. And what we saw early last year is that those counties, especially upstate, where we implemented the COTIs, the Centers of Treatment Innovations, where we brought telehealth, we brought mobile capacity to very, you know, rural areas where there was no treatment, we saw a drastic decrease in overdose deaths and even,

you know, emergency room visits.

So I think having that, the treatment and the access to that -- remember, we've also, through legislation, really increased access by flexing some of our regulations. We're out there training, you know, on Narcan. I think it's a combination of all that.

But certainly I think that, you know, the mobile treatment has been key. And the telehealth, it's been really, really tremendous for our population.

SENATOR SEWARD: And one final question, Commissioner. You know, as I read the Governor's budget, the amount of funds of approximately $240 million for heroin/opioid-related funding of various programs is flat. And could you share with us how these funds will be utilized -- generally, obviously. You can't talk about every single dollar -- but how these funds will be utilized, and do you believe that more funding would help combat even better this heroin/opioid epidemic in New York

State?

COMMISSIONER GONZALEZ-SANCHEZ: Well, what I could say is that there is a slight increase in our budget, at least the appropriated budget. The budget -- this current budget does allow us to continue all the work that we're doing, and yet some that are in the pipeline, like I indicated, having telehealth in every county, having the mobile treatment in each county.

So this budget does allow me to continue those efforts.

SENATOR SEWARD: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Assembly.

CHAIRWOMAN WEINSTEIN: Assemblyman Ra.

ASSEMBLYMAN RA: Thank you, Commissioner.

I just had a question with regard to the cannabis proposal. And I know there's been obviously a lot of discussion about this proposal publicly, it came up last year, and there's an office that's going to deal with a lot of the pieces of this.

But do you foresee, you know, any new needs within your department as a result of this adult use of marijuana potentially becoming legal in New York State?

COMMISSIONER GONZALEZ-SANCHEZ: Well, we will continue to work with DOH and the new office. We treat cannabis abuse right now in our system, and we will continue to do so.

It's premature to really say whether we're going to see a spike or not, you know. I can't really comment on that at this point.

ASSEMBLYMAN RA: Okay. And just -- so with regard to that, so whether there should be some piece of this, that some level of the revenue goes toward treatment or anything like that, you think it's premature until we see, you know, what potential increase in use we might see in New York State.

COMMISSIONER GONZALEZ-SANCHEZ: I really can't comment on that because I think those are negotiations that are happening right now. So I really can't comment on that point.

ASSEMBLYMAN RA: Thank you,

Commissioner.

CHAIRWOMAN WEINSTEIN: Senate.

CHAIRWOMAN KRUEGER: Thank you.

Senator David Carlucci.

SENATOR CARLUCCI: Thank you, Chair.

Thank you, Commissioner. It's great to see you. And thank you for your commitment to fighting addiction wherever it is. And it's great to always see you in the district, at openings. And my office has had a great partnership with your office in doing as many naloxone trainings as we can, and we've trained hundreds of people, and they've left with a kit. And every now and then I'll be in the community, someone will come up to me and say, Hey, I was at one of those trainings, I had the kit, I used it, and I saved someone's life. And you know, that hits you. And it says, Okay, we've got to keep doing this.

So one of the things I want to ask is, is there something in the budget we can point to that will be funding these naloxone kits to make sure that the programs that you're

doing to distribute the kits free of charge is continuing?

COMMISSIONER GONZALEZ-SANCHEZ: I believe it is in our budget. I couldn't really point it to you right now, but I'll be more than glad to give you that information.

SENATOR CARLUCCI: But you're satisfied that you're going to be able to continue that program and provide free kits?

COMMISSIONER GONZALEZ-SANCHEZ: Yes. Yes.

SENATOR CARLUCCI: Okay. Then I wanted to ask about -- one of the things that just drives me crazy is hearing about the access to -- we've heard about medical-assisted treatment and methadone. And we know that the federal government has allowed for take-home doses to exist.

But it seems that in New York State that hasn't been as thorough or as accessible as we'd like. I mean, I have people that I know travel hours every day to get access to methadone just to live an independent, productive life. And we know -- we see our

corrections units going down the Thruway all day long, or through our local roads, because they don't have access to methadone locally.

What we've heard, though, on some of the programs is that because of New York's Medicaid reimbursement system, the way that it's set up is that it disincentivizes the take-home-dose program. As you know, it can be 30 days that someone can have a take-home dose, under the guidelines of the federal government.

Can you speak to that? What are we doing to make it easier? Is there something that I'm missing? Is there a problem with moving it in a way that would incentivize to have more of these take-home dose options?

COMMISSIONER GONZALEZ-SANCHEZ: I really feel uncomfortable speaking about the whole Medicaid situation because that's outside of our purview. That's more of a Department of Health question. We continue, as always, working with localities where there is a need for medication-assisted treatment. We're doing it via the vans, the

mobile vans. We're doing the best that we can with what we can under our jurisdiction.

But when it comes to the whole, you know, Medicaid billing and so on, I really -- I can't speak to that.

SENATOR CARLUCCI: Okay, I could appreciate that.

With that said, we can't dive into Medicaid, we don't have them here at the table with us today. But are there other roadblocks that you can see that we could be proactive with under this agency to make methadone more accessible in New York State?

COMMISSIONER GONZALEZ-SANCHEZ: Well, we continue to move forward, you know, making sure that our regulations speak to access, individuals having access. I think that we have really done a tremendous job in that.

We're continuing to work with individuals and, you know, educating them around medication-assisted treatment, and we will continue to do that. I think that there's still some gaps, some communities that still don't understand that, you know,

buprenorphine is a medication. And that's something that, you know, we need any help we can in getting people to understand that it is.

But like I said, you know, we continue to work with the criminal justice system, the judicial system, to get that across.

SENATOR CARLUCCI: So what would you say, what is the biggest roadblock right now for access to methadone in New York State?

COMMISSIONER GONZALEZ-SANCHEZ: I don't know that I would say there's a roadblock. I think we need to look at some of our insurance payers. I think that's an area we really need to look at. Because, you know, people say it's a block, but it's really the payers. So we need to do a better job of talking to our private insurers as well as Medicaid managed care plans.

SENATOR CARLUCCI: Thank you.

COMMISSIONER GONZALEZ-SANCHEZ: Thank you.

CHAIRWOMAN KRUEGER: Assembly.

CHAIRWOMAN WEINSTEIN: Assemblywoman

Rosenthal.

ASSEMBLYWOMAN ROSENTHAL: Okay, thank you. So in terms of sober homes, where I ended last time -- and I've heard many stories where they set their own rules. And if someone, you know, comes two minutes late then the management can say, Okay, you're out of here. Or they say abstinence only, but for a person who's on buprenorphine, that's abstinence for them, they're not using heroin or other opioids.

So -- and I have a bill to address this issue. But what -- I think OASAS -- I'd like to hear what you think the role should be in terms of sober homes where people with substance use disorder go.

COMMISSIONER GONZALEZ-SANCHEZ: Okay. So this comes up every year. Sober homes, we don't monitor -- our sober homes are not part of our continuum of care. That's probably part of the reason why there's so many issues with sober homes.

We do have our own system of housing within our portfolio. And I have in the past

said and I continue to say if you have sober homes that want to be monitored and regulated by OASAS, then, you know, they're welcome to apply.

The -- you know, I can't -- I can't tell a sober home that's not under our purview to follow our regulations. I could only do that with individuals that are licensed under us. And that's the issue with sober homes.

ASSEMBLYWOMAN ROSENTHAL: Okay. I mean you correctly point out, because there really is no oversight, that it's a free reign to do whatever they want. And that does need to change.

COMMISSIONER GONZALEZ-SANCHEZ: I think that -- you know, to a certain extent I also think that's a local issue that needs to be addressed as well. Because some of these entities, you know, are they zoned properly? I mean, I really don't want to get into that right now. But who monitors and who decides I'm going to become a sober home, and how does that happen?

ASSEMBLYWOMAN ROSENTHAL: Exactly. Exactly. And the sober home creators do say, Ooh, let me get your Medicaid money. And so they have a certain responsibility back to the state to not have these kinds of frivolous power, you know, moves when a person is in treatment or other circumstances.

So the Governor vetoed a bill that I cosponsored with Senator Harckham about prior authorization. He did sign a bill that commercial insurance would no longer have to comply with -- would no longer have a prior authorization issue, yet people on Medicaid would still have to undergo prior authorization. And at times that is going to bollix up their whole treatment. Because when a person needs their buprenorphine, for example, there's no time to waste to wait some days or even a week for prior authorization.

How do you think that your agency or others can attempt to make things right for Medicaid patients?

COMMISSIONER GONZALEZ-SANCHEZ: So a couple of things, a couple of comments.

Again, that's a DOH jurisdiction, Medicaid.

But I just want to clarify that no one will go without medication. I think that what the Governor is proposing, this standardized formulary would address a lot of other issues that we're not talking about when it comes to the formulary.

There are different forms of buprenorphine. We have approximately 17 or 18, something like that, managed care programs, right? Entities. They all cover different forms of buprenorphine. It's really chaotic . It's chaotic for the person, the prescriber; it's chaotic for the individual receiving the prescription. Sometimes they go to their local pharmacy, the pharmacy is not even stocked up.

So having a standardized formulary where you have access, everyone's clear on what forms of buprenorphine are covered by the managed care entities, I think goes a

long way.

But I need to clarify: No one will go without their buprenorphine. And if there is -- I've got to finish. If there is an individual that's on a particular form that their managed care company does not cover it, they have a -- we have in statute a five -- they could get five days of the medication, and they also have a quick turnaround time for prior approval. That's in statute as well.

ASSEMBLYWOMAN ROSENTHAL: Thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

Senate?

CHAIRWOMAN KRUEGER: Thank you. I'm going to offer a few questions.

So I was very disturbed that you were hypothesizing whether the number of people having opioid overdoses was going up or down statewide and whether it was the same people having multiple -- and then Narcan or something else saving them, or whether they were unique independent overdoses.

So I'm going to ask you to submit a

document, a chart to the committees that shows how many people had overdoses, how many died, and whether -- if you know -- how many multiples there were of the same people, that the success of having access to Narcan treated them.

Because in your testimony you talk about in the counties where you have X operating -- and then Pete Harckham had a map that showed holes in the counties. But I think we really want to know county by county what the story is and whether we're going up or down.

COMMISSIONER GONZALEZ-SANCHEZ: So can I clarify?

CHAIRWOMAN KRUEGER: Yup.

COMMISSIONER GONZALEZ-SANCHEZ: The map that Senator Harckham had had nothing to do with overdose deaths.

CHAIRWOMAN KRUEGER: Okay.

COMMISSIONER GONZALEZ-SANCHEZ: It had to do with the ombudsman program.

And I did not hypothesize of whether the deaths are going up or down. As a matter

of fact, I didn't want to comment on a Department of Health database because I don't have that data to comment on. I don't -- I didn't hypothesize that the numbers are going up or down. In fact, in some areas they are going down and in some areas they're plateauing and in other areas they're just going up slightly.

CHAIRWOMAN KRUEGER: So you do have that data available.

COMMISSIONER GONZALEZ-SANCHEZ: Yes. And the data that I have -- let me be clear -- I also work with the Department of Health to get. Because they're the ones that have that data. They get it from the hospitals. That's the only way I would be able to get that data.

CHAIRWOMAN KRUEGER: Well, if you died, they would get it from the hospitals, perhaps. But if you were saved and never even got to a hospital, it wouldn't be hospital data.

But I think you're right, that the Department of Health should still have that

data in their data collection. But you should also have easy access to that kind of data.

COMMISSIONER GONZALEZ-SANCHEZ: Yeah.

CHAIRWOMAN KRUEGER: And then you were asked several times -- and I'm just totally confused. Federal law says that they can give you Medicaid if you are moving, transitioning from one program or jail to somewhere else so that you don't have an interruption in medications that are helping ensure you don't go back to the kinds of drugs we don't want you on. And you've said several times you can't comment about how DOH handles this.

You have many sort of arrangements with the Department of Health where you do things together. I remember when you were going through and moving methadone clinics to being full health clinics so that people who were going for methadone were getting full healthcare at the same sites, because that was very rational.

What is it that prevents the State of

New York from making sure that people can continue medication uninterrupted so that they don't find themselves perhaps up to 30 days with no access to medications that we know they were on and are working?

COMMISSIONER GONZALEZ-SANCHEZ: So I guess I would rephrase my answer by saying that I would need to discuss with the Department of Health to see what are the issues, if any, preventing us from doing that.

But right now I'm not -- I'm not prepared to respond to the specifics of that.

CHAIRWOMAN KRUEGER: But these are people coming out of where?

COMMISSIONER GONZALEZ-SANCHEZ: Prison.

CHAIRWOMAN KRUEGER: Prison? So when they're in prison, we know everything about them. We've got all the I.D., we've got every piece of information. And there certainly are models where people are signed up for Medicaid while they're still pending release from prison. We've had that model in

a variety of places throughout the state.

So pretty much it's exclusively when you're leaving prison and we know you have been in a drug program where you're getting medicine, and we wanted to make sure you continue that medicine. Right?

COMMISSIONER GONZALEZ-SANCHEZ: Right.

CHAIRWOMAN KRUEGER: Okay. It may take DOH cooperation, it may take DOCCS cooperation. But this seems to me to be a no brainer and that we want to make sure we're not leaving people hanging out there for 30 days without the treatment that they have been responding well to. Because you're setting them up for a couple of things.

One, you're of course setting them up to go back to their addiction problem. And two, you're likely setting them up to just get sent right back to the state jails because they've flunked the test of sobriety.

So it just seems, again, this is a win/win or a lose/lose, and we're currently in the lose/lose column. So I hope that we can move to the win/win column quickly.

Another follow-up question -- and Pete Harckham raised it, and I think Linda Rosenthal raised it -- just the inadequacy of enough money for drug treatment. You and I have talked about in the past the problem we see in New York City where you're on the streets, you haven't been open to going into shelter, you are very often a dual mental illness and substance-abusing person, and suddenly because of the work of the outreach teams, usually, the person says, "You know what, yeah, it's time, I need help, I need treatment." And they need to get them residential treatment right away.

And we even had a meeting maybe two years ago now with your team and the city's HRA and homeless services team and I think Department of Mental Health, and you had a number of programs that were just about to open and were going to help address this.

Did they open?

COMMISSIONER GONZALEZ-SANCHEZ: Are you talking specifically for the teams in the shelters?

CHAIRWOMAN KRUEGER: You had a number of different programs. But you also were committing to more residential on-demand for people who were on the streets with a combination of substance abuse and mental illness.

COMMISSIONER GONZALEZ-SANCHEZ: Well, we do have a couple of programs that have opened up throughout the state to do exactly that. I don't have the list -- I don't remember the list. But I'll be more than glad to submit it to you and tell you when they started, how they're doing, how many people they're serving, and so on and so forth.

CHAIRWOMAN KRUEGER: Okay. That would be appreciated, thank you.

Assembly?

CHAIRWOMAN WEINSTEIN: Assemblywoman Gunther.

ASSEMBLYWOMAN GUNTHER: So I have a question regarding -- I was in a clinic in Newburgh. And, you know, there's -- people fail on the other meds and often they stay on

methadone, you know. And you have to go to a clinic in order to get methadone.

And yet what my understanding is is that, you know, people travel from all over the Orange County area to get to this clinic. And they also, you know, usually in those facilities they have ID doctors, just general practitioners. And there's an issue with one-stop shopping for those folks.

Like, in other words, it has bathroom issues -- it's like some ridiculous thing that is stopping somebody to do their deal and get what they need to remain sober, but also going then on the -- maybe to the other side and getting medical care, like if there's an ID doctor and you have a co-infection with HIV or something like that, that you can't go from one side to the other. Whether it's one bathroom missing -- it's like ridiculous rules that the DOH has in place that are preventing people from one-stop shopping.

We're spending a boatload of money on Medicaid cabs and -- because you come for one

reason and then you go to someplace else for another reason.

So it's a cost saving and it's also something that when you have a captive audience, you really get to be able to do a thorough, you know, full-person evaluation. And there's a remarkable thing called like talking to one another between like an ID doctor, someone that's running the program, et cetera, et cetera.

And there's something that's stopping it, and I don't know what exactly the law on the books is. But I know that it would be much more cost-efficient, it would be better for the patient, it's more of a holistic approach in 2020.

And if you could look and see what we can do to maybe change that system. Because I think it's important -- I know that anonymity for many is very important. But again, you walk in with a tribunal of people from all different walks of life -- there can be, you know, the president and CEO and somebody else.

So I just thought I'd bring it to your attention because New York could save money on Medicaid cabs and it's also a convenience for many that are, you know, getting treatment. And also because of, you know, brutalizing their body for some time, they have to make sure that their health is in good order.

That's all I have to say.

COMMISSIONER GONZALEZ-SANCHEZ: Thank you.

ASSEMBLYWOMAN GUNTHER: I just went there. That's why I brought it up.

CHAIRWOMAN KRUEGER: Senator Pete Harckham, second round, to close.

SENATOR HARCKHAM: Thank you, Madam Chair.

So many questions, so little time. I'm glad Chair Rosenthal asked about housing, we'll check that off the list.

Let's talk about harm reduction. Over the last couple of months as we traveled around the state, we heard so much about, you know, before you get people in treatment,

we've just got to keep people alive and reach them where they are, wherever that may mean. Anything from needle exchange all the way to supervised consumption.

So what is the state doing, what are we doing now in terms of harm reduction, and what opportunities do we have to do more?

COMMISSIONER GONZALEZ-SANCHEZ: So as you know, we have, you know, flexed our regulations. There's no wording in our regs that says "abstinence only." We're very patient-centered in everything we do. We work with the individual where they're at. We don't force treatment on anyone. We work with them. And we will continue to do that.

SENATOR HARCKHAM: Any specific programs? That's kind of a generic philosophy. I guess what I'm looking for, what more can we do, particularly in our hard-to-reach communities, in terms of keeping people alive and harm reduction?

COMMISSIONER GONZALEZ-SANCHEZ: Well, you know, we're out, we have peers out in the street doing one-on-one work with

individuals, with Narcan, trying to get them into treatment if that's what they want. And we're going to continue to do those efforts.

SENATOR HARCKHAM: All right. Thanks.

One of the other things that we hear and see is the shortage of doctors who have the waiver for -- to prescribe certain types of medication-assisted treatment. What are we doing to try and incentivize more physicians, physician assistants and nurse practitioners into the program?

COMMISSIONER GONZALEZ-SANCHEZ: Well, I hear that often. Last year it was the same issue. I'm not sure that's accurate. I think we have quite a few ex-waivered physicians. I think the issue is whether they want to prescribe or not. That's another issue.

We now, of course, are working with DOH to ensure that the EDs start induction of medication-assisted treatment and then communicate with the community-based organizations to hook up the individuals if they at the emergency rooms cannot or do not

want to prescribe.

So we should have a better sense this year, once these things are fully implemented and we have the appropriate oversight to know how that's working. But we continue to work with physicians who want to be waivered. I believe we do a -- we have even assistance in doing the actual waiving, the teaching and so on and so forth, and we will continue that.

SENATOR HARCKHAM: All right. Speaking of the emergency rooms, we had heard from patient advocacy groups and treatment providers there are still emergency rooms in the state that don't have MAT-qualified physicians in the emergency room.

I know you're rolling that out, you've got a program for that. How soon before we close that gap and literally every emergency room in New York State has at least one MAT-certified physician?

COMMISSIONER GONZALEZ-SANCHEZ: So as I indicated, we will continue to work with the Department of Health, because they're the ones that have jurisdiction over hospitals,

to ensure that that happens.

But that is part of regulations right now, and they have to do discharge planning, that's appropriate, and they must start induction in the EDs. We need that oversight. So I will continue to work with the Department of Health to ensure that that happens.

But there are several EDs that are doing it already.

SENATOR HARCKHAM: Terrific. Thank you.

Thank you, Madam Chair.

CHAIRWOMAN KRUEGER: Thank you. I think we're done. Thank you very much.

COMMISSIONER GONZALEZ-SANCHEZ: Thank you.

CHAIRWOMAN KRUEGER: And our next testifier is Denise Miranda, executive director of New York State Justice Center for the Protection of People with Special Needs.

EXECUTIVE DIRECTOR MIRANDA: Good afternoon, Chairs Krueger, Weinstein, Carlucci, and Gunther, as well as other

distinguished members of the Senate and Assembly.

My name is Denise Miranda, and I am the executive director of the New York State Justice Center for the Protection of People with Special Needs. I would like to thank you for the opportunity to testify regarding Governor Cuomo's Executive Budget proposal.

Today I come before you on behalf of the more than 1 million New Yorkers in care with special needs. The Justice Center's work is directed by our steadfast commitment to protecting vulnerable people from abuse and neglect. It is our commitment to that focus that drives every aspect of what we do and every decision that we make.

We refuse to deviate from our mission because history has proven that this opens the door to bad actors who for years worked the system while hurting people.

CHAIRWOMAN KRUEGER: Denise, pull the mic a little closer to your mouth, sorry. Thank you.

EXECUTIVE DIRECTOR MIRANDA: Sure.

Thanks to the leadership of the Governor, and with your partnership, cases that previously had fallen through the cracks are now fully investigated and those responsible for abuse and neglect are held accountable.

Nearly seven years ago, the Justice Center was tasked with the important mission of protecting vulnerable populations, and we have learned a lot in that time. Some look at the young age of this agency as a detriment. I see it as an advantage. Because we are young, we are not entrenched in how we operate. Our processes are still evolving.

Every day we work at evaluating where we can be more efficient and build collaboration both inside and outside of the agency. Time and time again, we search for better ways to serve individuals, families and stakeholders.

In our continual pursuit to build and improve the Justice Center, we recognized a need to renew our focus on one of our largest

and most critical units -- investigations. We're getting back to the basics. The agency has implemented a new, intensive on-boarding and mentorship program for all new investigators. The program provides the resources they need as they learn to navigate these very complex cases.

In the past 12 months, we have continued to explore new and better ways to serve those we protect. The Justice Center's sexual abuse response team is now fully operational. This cross-disciplinary group is highly trained in the latest investigatory techniques and strategies. Our team takes a trauma-informed approach so that individuals will not be revictimized. Creating a cohort that has been trained by nationally recognized experts ensures our ability to bring justice to the victims and hold bad actors accountable.

But investigating allegations is only one part of what we do. Our prevention work continues to expand. More than 350 corrective action plan audits, 40 site

visits, and a dozen systemic reviews were conducted in 2019 to ensure providers are taking appropriate steps to stop abuse and neglect before it happens.

We continue to collaborate with our state oversight agency partners on the Interagency Abuse Prevention Workgroup, but this year we're going even further. Recently the Justice Center established its own internal workgroup solely focused on developing new prevention initiatives. We also introduced an in-person training for providers and staff on establishing professional boundaries.

This past year we added a new toolkit to our growing library of prevention resources: "The Dangers of Intestinal Obstructions." Justice Center data highlighted this as a serious, sometimes life-threatening issue for individuals receiving services. In addition, a toolkit featuring guidance on wheelchair securement will be coming out this year.

Engagement with stakeholders remains

an ongoing need for the agency. This has been a priority since my arrival three years ago. In 2019, we focused on helping organized labor understand our role in the workplace. We engaged in several sessions around the state with members of unions to share information about the Justice Center.

Outreach to providers and families has also been a top priority. The Justice Center held five regional conferences throughout the state in 2019. These free, day-long events gave attendees the opportunity to gain in-depth knowledge of the agency. The conferences continue to open the dialogue between the Justice Center and those we serve.

Another way the Justice Center supports individuals and families is through our advocates. Our team assisted more than 4,000 people last year and provided accompaniment services to more than 400 people during interviews. We also helped hundreds of families access investigatory records. As a result of their hard work, we

received additional grant funding and we were able to grow our staff of advocates in our high-volume areas.

Last but not least, we continue to build on our established foundation of collaboration with our state oversight agency partners. The Justice Center now holds monthly meetings with each state oversight agency.

We believe the work we have planned in the coming year will continue to improve the Justice Center. The safety and well-being of the individuals under our jurisdiction remains the foundation of everything we do. We do not deviate from this mandate, but we seek opportunities to enhance it in any way we can.

Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Our chair, David Carlucci.

SENATOR CARLUCCI: Thank you.

Thank you, Commissioner, Director. Appreciate your testimony here today and the work that you've done.

So just quickly, one of the things I wanted to make sure I asked you about was the change in the budget about the optional statewide central registry. And this is something that, after reading, is just difficult to explain to my colleagues and to advocates about what is being done here.

Can you tell us why this change is necessary and how the concern is that it will -- that it won't lead to adverse outcomes?

EXECUTIVE DIRECTOR MIRANDA: Sure, absolutely. And I appreciate the question because I know this issue has been a source of some confusion.

The SCR checks are part of our criminal background check for pre-employment purposes. Those checks are going to remain in place as they are. The proposal that's before us contemplates eliminating the need for the SCR checks to be mandatory when they're part of an investigation.

So this is not going to have any impact in terms of qualifications, background checks, et cetera, but it's really an

investigatory stage of our cases where currently we are mandated to do an SCR check.

The changes in the proposal still allow for that check to be discretionary if we choose to do so, but what we've found is that the SCR does not provide any value evidentiary-wise from the perspective of assisting us in our investigation. Our investigation is limited to the four corners of the allegations that are before us, and the SCR is, frankly, drains on resources that we have and we believe that it should be discretionary, not a mandatory requirement.

SENATOR CARLUCCI: And can you elaborate why it is a drain on resources? What's entailed here?

EXECUTIVE DIRECTOR MIRANDA: Sure. So we're talking about two to three hours for every single SCR check, which is a considerable amount of time, again, considering the weight that it will have and the bearing it will have on an investigation.

The SCR check, as many of us know, there have been a lot of concerns regarding

the SCR check. There are allegations that date back 20 years. And so from the perspective of deciding whether an allegation of abuse and neglect has occurred, whether we can substantiate or unsubstantiate, the SCR does not help us build evidence in a case.

SENATOR CARLUCCI: Okay. And so how often are you accessing that in a given year?

EXECUTIVE DIRECTOR MIRANDA: So for every single investigation that we do, we're currently required to run an SCR check for the subject involved in that investigation. So currently right now we're talking about, last year, 12 to 13,000 investigations. So it is a real impact on the agency and our ability to function.

SENATOR CARLUCCI: And what do you think that will -- so if we're going from 12 to 13,000 a year, what will that bring it down to, you think?

EXECUTIVE DIRECTOR MIRANDA: Well, as I mentioned before, it's discretionary. Right? And so if in the rare instance we find that this would be particularly helpful,

we still have the ability to make that check.

You know, again, I think a lot of the concern regarding the SCR check has been conflated with our background check process. That will remain in place. The SCR will still be part of the employment clearance process.

SENATOR CARLUCCI: And so what do you think -- what's your estimate in terms of if it's not mandatory, it's discretionary, how often -- will it be 50 percent of the time, 1 percent of the time?

EXECUTIVE DIRECTOR MIRANDA: That's going to depend on the investigations. Every single investigation is unique. We look at those cases individually. So I cannot at this particular point hazard a guess with respect to how often we would use the SCR.

What we have found thus far, with close to 70,000 investigations done since the opening of our agency in 2013, it has not proven to be helpful in terms of building a case of abuse or neglect or coming to a determination that a case should be

unsubstantiated.

SENATOR CARLUCCI: So from this it sounds like you would maybe never use it? Like when -- I'm just trying to understand when you would use this check.

EXECUTIVE DIRECTOR MIRANDA: It will remain discretionary. And we will evaluate every single case to determine if it's necessary. And if it's there, that resource will be available.

SENATOR CARLUCCI: Okay. Now, you mentioned that you've taken on 70,000 investigations since the start of the Justice Center seven years ago.

EXECUTIVE DIRECTOR MIRANDA: Correct.

SENATOR CARLUCCI: And what -- can you tell us, is there an agency that you have more cases out of than any other? Can you tell us that? And then have you seen a trend in terms of newer types of cases that you're getting? Could you speak to both of those issues?

EXECUTIVE DIRECTOR MIRANDA: Sure.

So currently our cases, approximately

50 percent of those cases are related to the state oversight agency of OPWDD. That does represent the bulk of the investigations that we do.

We're constantly analyzing our data to identify trends. These trends help inform our prevention tools that we create every single year. As I mentioned in my testimony, we do a "Spotlight on Prevention." We've done six of these. A lot of the determination of what the topic will be. It's based on the trends of what we're seeing in terms of investigations and allegations that are coming in.

So we've created spotlight kits on intestinal obstruction, we have another one that will be forthcoming on wheelchair securement, we've done one on caregiver fatigue, safety for individuals left in vehicles, and another one on restraints, on how to eliminate or diminish the occurrence of restraints.

So all of those topics are based on the data that we're seeing in terms of the

number of cases that are coming in, and we continue to review that data every year to help inform our choices.

SENATOR CARLUCCI: Okay. So you mentioned those six categories. I'm just trying to follow you here. So you had the wheelchair constraints -- that is a report that you're putting out or --

EXECUTIVE DIRECTOR MIRANDA: So wheelchair securement. What we've seen is a trend in individuals being injured because they have been improperly fastened within a vehicle. Right? And so this is a real concern, because those injuries can be quite serious if a person is not appropriately secured, especially in a moving vehicle. And so that has informed our decision to make sure that we're creating a toolkit which will be released this year.

All of this information is available on our website. Our toolkits, besides education and resource materials, there's also a lot of material there for providers in terms of self-assessments as well.

SENATOR CARLUCCI: So you would say that -- the question was about trends that you see, and the response is that there's these toolkits that are put in place when you do see a trend. Is that what I can gather?

EXECUTIVE DIRECTOR MIRANDA: That's correct.

SENATOR CARLUCCI: Okay. And so what were some of the other ones that you were talking about? I got confused with the regional meetings that you're doing to do outreach and educate the workforce, and then the trends that you're seeing. So you've got the wheelchair restraints --

EXECUTIVE DIRECTOR MIRANDA: So the topics of the Spotlight?

SENATOR CARLUCCI: Yeah, like --

EXECUTIVE DIRECTOR MIRANDA: Reduction of restraints --

SENATOR CARLUCCI: -- what I'm trying to understand is what you're seeing, because you're seeing 10, 12 to 13,000 cases a year, and what -- are there any types of things that we should be concerned about or know

that have been changes in the past seven years? Things that you see that are increasing in more frequency.

EXECUTIVE DIRECTOR MIRANDA: So with respect -- besides the Spotlight on Prevention, right? Which as I discussed, those topics are based on the data and the trends that we're seeing of abuse and neglect.

We also have a very consistent data point with respect to the cases that are substantiated. Approximately 75 percent of our cases are substantiated at Category 3. Category 3 is our lowest category for abuse and neglect. That statistic has held consistent for the past six years.

So what we see there is thankfully a couple of things. Number one, there's a low rate of criminality within the service settings, which is a good thing. The majority of the cases that we do investigate are Category 3 and, thankfully, not the most egregious cases, although those certainly do occur and we have those cases within our

jurisdiction.

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

SENATOR CARLUCCI: Okay, thank you.

Thank you, Chair.

CHAIRWOMAN KRUEGER: Thank you.

Assembly.

CHAIRWOMAN WEINSTEIN: Assemblywoman Gunther.

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

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

this particular year.

I think the question that usually follows that particular question is, so what are we doing right now? How are we handling cases? What about the criminal cases that we're actively involved in?

So as I mentioned, the issue here is independent authority, right? And the crux of the issue is really do we need the consent of the county DAs. Our position is that we don't. However, as a safeguard and a preventative measure, we have sought the consent of the county DAs on all the criminal cases where we are involved.

I think it's important to note we have never prosecuted a case over the objection of any single county DA. We work collaboratively with them. We enjoy a very cooperative relationship. And irrespective of the outcome of this case, we will continue to make sure that we're removing bad actors from the workforce.

ASSEMBLYWOMAN GUNTHER: And what about like -- if the communication with parents is

unchanged, as far as the Justice Center goes, on changes in any policy or procedure? There's a good line of communication?

EXECUTIVE DIRECTOR MIRANDA: Sure. So communication, engagement, quite frankly, transparency, has been a priority since I arrived here three years ago. I'm very happy to share that last year we launched a series of regional conferences. We did one conference in every single region, so there were five last year.

This was a perfect opportunity for family members, provider associations, and smaller nonprofits to come and speak with executive staff of the agency, to receive updates, to get more information, to answer questions. And then in the afternoon we had sessions that were specifically focused on some very unique parts of the agency. So there was a topic of investigations, there was also another panel discussion regarding our criminal background check.

These were very well attended. We plan on renewing that effort and launching

another series this year.

ASSEMBLYWOMAN GUNTHER: Well, I for one have received less complaints about the Justice Center, which is great. And, you know, one of the largest employers in my district are people that care for people with disabilities. So thank you for what you've done.

EXECUTIVE DIRECTOR MIRANDA: Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Senator Jim Seward.

SENATOR SEWARD: Thank you, Madam Chair.

And Director Miranda, good to see you again.

I know in the past -- I'm talking about in the past -- a chronic complaint that we had heard about the Justice Center was the length of time of investigations. And I know -- I think last year when you were before us we had a discussion about that and you were looking to shorten those times.

Can you give us an update in terms of

the length of time of investigations?

EXECUTIVE DIRECTOR MIRANDA: Sure.

So currently our average cycle time for investigations is 69 days. Since we last met here and spoke last year, we've taken on several initiatives. We had the expansion of one of our regions, we opened up an office in White Plains in Westchester County. We do that because we are constantly looking at the data, trying to identify places in the state where we need to deploy more resources. You know, resources impact cycle times.

We work with the providers as well to ensure that they are familiar with our internal processes. You know, cycle time is a priority, but it's also very nuanced and complex. Cycle time is going to be impacted by the type of case, the complexity of the case -- sometimes we have multiple subjects, sometimes we have multiple witnesses, sometimes these investigations need to be coordinated with labor unions or perhaps counsel. We also rely on the provider or the employer to supply us with the necessary

documents to review.

That said, cycle time is always a priority for us. Recently we actually expanded a program where we're now allocating three business days to get additional information for a provider. So in this pilot program -- we've put about 2500 cases through this pilot program, and what we've found is that 65 percent of those cases have been reclassified.

This is particularly important because we do not have discretion as an agency when it comes to a call that's coming in. If an allegation of abuse and neglect comes in, we are mandated to do an investigation, to reach a conclusion, a substantiation or unsubstantiation. We have to make a classification based on that call.

There are instances where perhaps there are gaps in the information, and so the three business-day extension, for lack of a better word, allows us to seek additional information oftentimes from the provider, so that we can make a much more accurate

classification. This has had a tremendous impact on cycle time because it allows us to make sure that we're deploying resources for the cases that need it most.

SENATOR SEWARD: Thank you for that update.

There -- there continues to be some concerns that the Justice Center has, shall we say, a law enforcement approach to all investigations regardless of the nature of those investigations in the original complaint. This can lead to fear and anger among the provider staffs that are out there.

How do you respond to those allegations, and what actions have been taken to take care of that?

EXECUTIVE DIRECTOR MIRANDA: So that was a concern that was articulated when I arrived here at the agency, and I think we've gone to great lengths to make sure that we're dispelling that myth.

You know, first and foremost we have 199 members of our investigatory unit; only 25 of those are sworn police officers. But

we do understand that sometimes, you know, the actions of one or two can color an agency, and so we've been extremely committed to making sure that we're providing training for all of our investigators on forensic interviewing, best practices, working with disabled populations. And quite frankly, also reminding our entire agency -- in particular our investigators -- that an investigation is a traumatic event, whether you are a witness, whether you are a subject, whether you are a victim on a particular case, and making sure that we're using a trauma-informed approach when speaking with people. Very important.

Additionally, we record all of our interviews at the agency so when there is a concern with respect to the tone or the conduct of an investigator, this provides us with an opportunity to actually review the recordings and make sure that the conduct is on par with our expectations.

SENATOR SEWARD: I do like your emphasis on -- in your testimony and your

answers, on prevention and working with providers to avoid problems before they come up.

EXECUTIVE DIRECTOR MIRANDA: Absolutely.

SENATOR SEWARD: One quick final question in terms of the applicants for background checks that you do for the various agencies. You're looking at 13,000 applicants, but only a very small number, 380, were disapproved.

How do you account for that, such a small percentage, being disapproved?

EXECUTIVE DIRECTOR MIRANDA: So actually our statistics for last year, we did 100,000 criminal background checks. And so there was a small number that were not approved for employment due to criminal-history backgrounds. So our volume is actually significantly higher.

The number -- the amount of people who were not approved, you know, this is based on the criminal history and an assessment that's done during the criminal background check

process.

SENATOR SEWARD: Do you have a -- any speculation why there's such a small number? Were those -- those maybe don't apply if they have a --

EXECUTIVE DIRECTOR MIRANDA: Thankfully, mm-hmm.

SENATOR SEWARD: Yeah. Thank you.

EXECUTIVE DIRECTOR MIRANDA: Sure.

CHAIRWOMAN KRUEGER: Thank you.

Assembly? No?

We're done. Thank you very much. Appreciate it.

EXECUTIVE DIRECTOR MIRANDA: Thank you.

CHAIRWOMAN KRUEGER: {Mic off.} I have to leave for a meeting, but my very capable cochair will be here in the interim.

CHAIRWOMAN WEINSTEIN: Thank you.

So now we begin the portion of the hearing for the nongovernmental witnesses. And just a reminder, the witnesses have up to five minutes to present their testimony. As you were forewarned in the beginning, it

would be best, especially since we've received your testimony in advance, and it has been circulated to all the members, to try and summarize and not read word for word; you end up not getting through it.

And just a reminder to members, any members with a question are limited to three minutes for question and answer.

So now we have New York Association of Psychiatric Rehabilitation Services, Harvey Rosenthal, executive director.

MR. ROSENTHAL: Good afternoon. Thank you to the chairs and members of the committee for your long-time partnership, thoughtful oversight, and support of the thousands of people with serious mental illnesses and the providers that we support at NYAPRS.

This is my 25th annual budget testimony, having begun in 1995. And I actually began my work in the field working at the State Psych Center here in Albany in 1977. And at that time, a diagnosis of mental illness was a life sentence; severe

functional limitations and frequent illness and relapses were considered the norm. Medication, hospitalization and community institutions were the only major treatment options, and people were rarely, were rarely considered capable of good judgment.

Since the '80s we've all worked together -- the providers, the consumers, and government officials -- to raise the bar for what's possible for people with mental illnesses and what should be required from our provider system. State mental health policy is a very personal issue for me, my community. I have a mental illness, and many of the people who work in my office do, and agency.

The lens through which we view the budget has been based on the view that everyone can recover, everyone can take on responsibility, everyone can deserve the dignity of an independent life in the community and stable housing, employment, and culturally good supports. That's the lens that I'm going to offer this testimony.

The first issue I'm going to talk about is the community -- funding for the community services and the workforce. It's important to distinguish that the money that's been made available that you've heard about, which is the 2 percent, is only for the workforce and only for the workforce that works for agencies that are funded by OASAS, OMH, and OPWDD. So we're not talking about the thing we've looked at, the COLA that's been denied for over a decade. We are talking now about across-the-board increases for the agencies as well as the workforce. Because those agencies are in a state of crisis that you'll hear a lot more about.

Our group, which is the statewide #3for#5 campaign, is calling for a 3 percent increase across the board for each of the next five years. And you'll hear that this coalition is made up of an unprecedented coalition of nonprofits across the human service spectrum.

When it comes to Medicaid, we're quite anxious about what we're going to hear in

Medicaid. We're worried about cuts. We're grateful that we haven't been cut, as other sectors were, by the 1 percent, and we're looking for those kind of protections in the coming budget. Since so much of the work relies on the MRT, we want the state to ensure there is significant representation from the mental health community, consumers and providers, and to allow for the active level of participation I had in the past as a member of the MRT.

Stable housing with individual supports is fundamental to promote the health, safety and dignity of people in recovery. We're grateful that there's a 20 million add in this budget, and 60 million for capital funds. More is needed. You'll hear more about that.

There's a line in the budget, in the OMH budget, that talks about increasing the capacity in emergency departments. But all it does is increase one more day of reimbursement. It misses the point. People are waiting in emergency rooms -- I visit

them, I see that -- for days, waiting for an assessment. There is simply not enough staff and facility, and we need to do more about that than increase reimbursement by one day.

This budget increases -- permits, for the first time ever, the use of Medicaid in institutional settings. The IMD exclusion that has set the tone for that has prevented states from using Medicaid to expand institutions. This budget takes a step that we're very concerned about that will allow Medicaid to provide services in an inpatient setting.

You heard about the adult home residents and the need for more services for them. Over the last I think it's seven years, only one in five of adult home residents with psych disabilities who were supposed to leave have left. The state needs to do a lot more. We want to work with them on that.

In terms of criminal justice reforms -- I'll end with that -- there are three parts. Crisis intervention teams --

Senator Carlucci has been terrific on that. We've had several millions of dollars where police are trained and supported not to arrest or harm people and keep them out of the criminal justice system.

We're very focused on diversion; Mrs. Gunther has been great in funding an alternative program in Westchester County that helps keep people out of prison and jail.

We want the passage of the HALT Bill that will ban solitary confinement of people with mental illnesses and limit it for other populations. And I will stop there.

CHAIRWOMAN WEINSTEIN: Thank you.

Questions?

ASSEMBLYWOMAN GUNTHER: I think you covered everything. And I know I'll see you in my office if --

MR. ROSENTHAL: Okay, I'll be there.

CHAIRWOMAN WEINSTEIN: Thank you.

Next, Mental Health Association in New York State, Glenn Liebman, CEO.

MR. LIEBMAN: Good afternoon. I want

to thank the Ways and Means Committee and the Senate Finance Committee as well as our chairs, our terrific chairs of -- you know, both Assemblywoman Gunther and Senator Carlucci have been outstanding supporters of the Mental Health Association and support for mental health services.

So really today is about two budget narratives. The first one -- and Harvey did a great job of describing -- considering this economic climate, this actually was a pretty good budget, relatively. Good credit goes to Governor Cuomo and Commissioner Sullivan in reflecting a budget with no major cuts to mental health services. We were protected from the first round of Medicaid cuts and actually added funding for housing as well as keeping the commitment to the direct-care workforce.

But there's also Narrative No. 2. And you all talked about it today with great passion, and I heard this. This is not only about New York, this is the country. We are in a mental health crisis. And it's great

that the budget's been positive, but we are in a crisis.

And I've been doing this for 17 years and I rarely have said the word "crisis," but this is what we are doing. Individuals and families are suffering. We heard the stories about six-month waiting lists for services, two-year waiting lists for housing, overworked and underpaid workforce, exploding rates of anxiety, depression, and suicide attempts among young people, shortage of mental health professionals, suicidality among veterans and discrete populations, people not getting Medicaid for months as they're released from jail and prison while spending all this time -- so much of their time, unfortunately -- in solitary confinement as well.

So how do we respond to this crisis? There are no simple answers. And frankly, New York is better that virtually any other state. But we're not here to blame or to point fingers. We're here for fixes. And yes, these fixes cost money. And yes, we're

in a budget of fiscal constraint. But the reality for us in mental health is that it doesn't matter if it's a good budget or a bad budget, we always only get a small slice of the pie.

The reality is we're not a small slice of the pie. We actually comprise almost the entire pie. One in five people in the United States has a serious mental health issue. Almost half of all Americans will have a diagnosed mental health issue in their lifetime. I doubt there is anyone in this room, or anywhere that we know of, that has not been either directly or indirectly impacted by mental health and mental illness, whether as a family member, themselves, or as a close friend.

In the context of our following recommendations, we urge you to keep this in mind, the importance of what we're advocating for, and the significance of financial support for our stated goals.

So I have here -- obviously I'm not going to read it -- I have about 26 different

recommendations. And I'm going to focus really on two things in particular. And that's not to minimize all the other 24 other things, because they're all equally as significant. But what I'm going to focus on right now -- and Harvey talked about it as well -- is the #3for#5 campaign.

So this is an unprecedented move whereby the entire human service sector non-for-profit community is speaking with one voice -- and you're going to hear from other people today too. Mental health, developmental disabilities, addiction disorders, aging, child welfare, domestic violence, we're all speaking with one voice. We're all advocating for a 3 percent increase in funding for the next five years. So that's where the campaign is, the number 3, "for" spelled out, f-o-r, 5. Three for five.

We've lost over a billion dollars in the last decade by COLAs not being part of the human service sector. We were supposed to get a COLA every year for the last 11 years. It's been carved out every year,

unfortunately. We've lost -- our entire sector has lost over a billion dollars. Think about how these nonprofits provide service and support for those in greatest need, and think of how different our lives would be if we had that funding.

We are the safety net for these people. And for those of us in mental health, what the safety net means is housing, care management, respite, clinic services, medication management, peer support, employment, education and much more.

We get two questions a lot in this campaign: Why this year, when we know this is a difficult budget year? The bottom line is, we don't pick a year. This is a fiscal crisis. We're in a financial crisis. We can't say that, jeez, we should start the #3for#5 campaign next year or the year after. We are in a crisis. Everybody here today is going to talk about this, because this is the reality.

And we do appreciate the 2 percent across-the-board funding cut -- I mean,

funding increase for the direct care workforce. We do appreciate that very much. But the bottom line is we need more and our entire sector needs more.

And the other thing is, we're the taxpayers' best friends. We are economic drivers in the community, but we're also taxpayers' best friends. When you're talking about things like -- what are we talking about here? With DSRIP and Medicaid managed care and everything else, it's all dedicated to keeping people out of expensive settings and in the communities. That's what we do in the nonprofit sector every day. We are doing really great work in the community, and we're saving people money as well.

So we hope that as we move forward, that that $170 million we're asking for will be added in the budget.

Do I have time for one more quick thing? Or I'm being --

CHAIRWOMAN WEINSTEIN: Just finish up that -- finish up your last thought.

MR. LIEBMAN: Okay. Mental health

education in schools, really significant. We really appreciate the support of our chairs in this area. And we have a handout in the back of the report about the work we're doing in schools and communities around mental health and our resource center.

And we appreciate Assemblywoman Gunther putting us -- initial support, as well as now the Governor in the last two years.

And we also appreciate -- Senator Carlucci's just introduced a bill last week around teacher training, and that's the next step forward in terms of teacher education -- I mean, around mental health education in schools.

So thank you very much.

CHAIRWOMAN WEINSTEIN: Thank you.

Senator Carlucci.

SENATOR CARLUCCI: Thank you, Chair.

Thank you, Glenn.

I wanted to ask you about -- you touched on mental health first aid and the importance of that. So I was going to ask

you about that. But I also wanted to ask, because you didn't get to it, about crisis intervention teams.

MR. LIEBMAN: Yes.

SENATOR CARLUCCI: I know the Mental Health Association in New York has been really pushing that initiative. Could you tell us why that's important and why we need to put it in the budget?

MR. LIEBMAN: Sure. And again, we appreciate your leadership in that area, because it does mean a lot. And you're going to hear, you know, NYAPRS is talking about it, and you're going to hear from NAMI as well about how important it is to a lot of us.

Basically, crisis intervention teams are a best practice that brings together law enforcement and individuals and their families who are in crisis, in a mental health crisis, to plan, be planful in the process -- what should law enforcement look for, what should they pay attention to when somebody's in a current crisis, how do we

minimize that crisis and make sure that, you know, we don't have those terrible outcomes that we so often have.

And so we're very appreciative of this funding. It is a best practice, and it's going on in counties around the state now. And this is relatively new, this is only in the last five years, because for years New York was behind the 8-ball on this, and now, you know, with your leadership and the other leadership, we've really been able to really implement some really strong work around CIT, which is really a positive for everybody in our community.

SENATOR CARLUCCI: Great. And what do you think we need in terms of funding in the state to meet the needs to have more law enforcement trained in crisis intervention?

MR. LIEBMAN: Well, you know, I'd have to do an environmental scan to find out how many counties already have CIT and how many counties need to have CIT. Because everybody wants it, and I think it would be appropriate for everywhere. So I don't know exact

numbers, but I think that's appropriate.

And the other thing is -- and you know this well -- is that Mental Health First Aid, specifically for counties that have CIT -- in a lot of counties, as we know, law enforcement, it's hard for them to take a 35-hour training. Mental Health First Aid has been the perfect backdrop for those individuals who are interested in finding out more about law enforcement, how to work mental health and law enforcement. And Mental Health First Aid has been that ancillary piece that's been very helpful.

SENATOR CARLUCCI: And with Mental Health First Aid, you know, it's been great. I talk to my children's preschool teachers, they've taken the course, they've signed up for the eight-hour course.

Can you tell us how many people have been trained on Mental Health First Aid in New York State? Do you have that number?

MR. LIEBMAN: I don't have it for New York State specifically. I do have it for the country as a whole: 2.5 million

people have been trained in Mental Health First Aid across the country. And that's whether it's preschool teachers, you know, law enforcement, librarians -- every sector has been taught in Mental Health First Aid.

And I know that we in New York State have done -- again, over the last several years we've gotten the funding to be able to go out there, and our members are certainly doing it around the state, and I know there have been hundreds of trainings that are going on consistently around the state.

SENATOR CARLUCCI: Thank you, Glenn.

Thank you, Chair.

MR. LIEBMAN: Thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

Thank you for the work you do on this issue.

MR. LIEBMAN: Thank you.

CHAIRWOMAN WEINSTEIN: Next we have the National Alliance on Mental Illness-New York State, Ariel Coffman, president.

MS. BURCH: Good afternoon. I'm actually Wendy Burch. I'm the executive

director for NAMI-NYS.

Our organization represents thousands of New Yorkers living with a mental health condition, as well as their family members. I appreciate the opportunity to present testimony today, and thank you for allowing me to do so.

We have submitted our written testimony to you, so of course in the interests of time, I'd just like to take a moment to highlight some of the needs we see in the course of our work at NAMI.

First we want to ensure that those who need it have access to care and services. We recognize that people living with mental health issues, when provided with appropriate services in a timely manner, can live healthy and productive lives.

Having the necessary supports in place can prevent long-term hospitalization, homelessness, incarceration, and the risk of them taking their own lives.

This is the reason that NAMI-NYS has joined the #3for#5 campaign. Access to care

begins by having human services agencies who have the ability to run their programs in a way that allows them to provide the continuity of care that is critical to recovery. It is significant and speaks to the seriousness of the situation that so many providers and supporters across human services have come together to support and promote this campaign.

We urge you to lend your support as well and institute the 3 percent increase in funding for nonprofits in the human services sector every year for the next five years.

NAMI-NYS was pleased to see that the Governor's budget reflects the importance of adequate community-based mental health housing by including an additional $20 million for existing residential programs. However, this investment still falls short of what is needed to address the quarter-century of flat funding to nonprofit mental health housing programs.

We urge the Legislature to close the gap in funding these vital programs.

Recovery is only possible when a person first has a safe and stable place to live.

Along with residential and treatment services, crisis services are also desperately needed. NAMI-NYS believes that no one should have to travel more than an hour to access psychiatric emergency crisis services. Unfortunately, this goal is unattainable for far too many New Yorkers. We need investments to expand both mobile crisis services such as assertive community treatment teams and mobile intervention teams, as well as stationary options such as crisis stabilization centers and respite centers.

We would like to commend the Governor and the Legislature for their support in several areas. The first is in the area of parity for mental health. The establishment of an ombudsman to oversee parity in the CHAMP program, and now the Behavioral Health Parity Compliance Fund, will help to ensure that mental health issues are treated fairly by insurance companies.

We would also like to commend the Legislature for its commitment to improving the criminal justice-mental illness interface, particularly the investment in crisis intervention teams. We hope to see an increasing emphasis on diversion initiatives, including the commitment to ensuring that psychiatric services exist, and are accessible, in which to divert individuals from incarceration to recovery.

Finally, as a former member of the armed services, I was pleased to see an investment of the $1 million for services and expenses related to suicide prevention efforts for veterans, law enforcement and first responders. The defenders and protectors of our nation deserve the support of the community, especially in times of personal struggle.

Thank you for the opportunity to provide input to you today. I know you will continue to invest in initiatives that support those working towards recovery so that they can truly be a part of the

community and lead healthy and productive lives. Thank you.

CHAIRWOMAN WEINSTEIN: Thank you for your concise testimony. As you noted, we do have the full testimony and it was circulated to all the members.

I don't believe there are any questions. Thank you for being here today.

MS. BURCH: Thank you.

CHAIRWOMAN WEINSTEIN: Next we have New York State Conference of Local Mental Hygiene Directors, Kelly Hansen, executive director.

MS. HANSEN: Good afternoon. My name is Kelly Hansen. I'm the executive director of the New York State Conference of Local Mental Hygiene Directors, and I appreciate the opportunity to present testimony to you today on the Governor's Executive Budget.

The conference represents the directors of community services and county mental health commissioners in each of the 57 counties and the Department of Mental Hygiene for the City of New York.

Given the five minutes -- you have my full testimony, but I want to spend my time on two specific pieces. One is to be able to report to you how the funding was spent that the conference had advocated for and you provided for jail-based substance use disorder treatment and transition services. It's on page 4 of your testimony.

And also I wanted to provide a clarification around the discussions that have occurred earlier around jail-based competency restoration and also the shift to the 100 percent county cost of state psychiatric center treatment for competency restoration.

So the conference, in partnership with our partners in the New York State Sheriffs' Association and also the New York State Association of Counties, two years ago were successful, with your help, in securing $3.75 million to be able to provide jail-based substance use disorder treatment. And the reason that we were advocating for this funding is because while the state had

developed a number of community services, we know that our folks traditionally have significant interaction with the criminal justice system, and they would be brought into jail and we had no funding to be able to provide services to them.

So last year's budget included the 3.75, the Governor continued that, and as Chairwoman Rosenthal had indicated --

CHAIRWOMAN WEINSTEIN: Why don't you hold on for a minute. Let's try and -- I'm not sure if it's your mic or the -- maybe try shifting --

MS. HANSEN: Switch? Okay.

CHAIRWOMAN WEINSTEIN: Yeah. I'm not sure if it's the microphone or the speaker feedback we're getting.

MS. HANSEN: I have a one-out-of-three chance to get this -- is this better? So far so good? All right, thank you. And thank you for stopping the clock, I appreciate it.

So as I was mentioning, there was 3.75 million in the budget. Our original ask was for 12.8, to be able to provide funding

for each of the counties outside of New York City. New York City has a well-established program.

We got 3.75. So the result of that was roughly $60,000 to each county to be able to provide those services. One of the pieces is that Herkimer County, with 58 people in their jail, got $60,000. Nassau County, with over a thousand individuals in their jail, got $60,000.

However, I'm pleased to report that we had done a very in-depth survey of our county mental health commissioners over the summer and asked, what specifically did you use this funding for, and did you create a new service or did you enhance an existing service?

So a few of the numbers I just want to point out to you is that 20 jails were able to create individual and group counseling services. Fourteen jails created peer services, which are so important. And 15 jails were able to put in place transition and reentry services.

So we have revised our budget ask

based on what we anticipate may be the impact of bail reform. We don't have a visual into what the numbers will change, but we do know that there will still be a need in county jails to be able to offer treatment.

So in addition to the 3.75, we're asking for another 3.25 to bring our total to $7 million. That's our ask.

Also, as part of last year's budget, there was another million added to pay for the cost of medications only in the jail. That, as you've heard, was not reappropriated, and we're hoping that that funding will be forthcoming.

The other piece I just want to quickly talk about is the provision for authorizing counties to do jail-based competency restoration. I can tell you that based on what I hear from my members, who are all clinicians, I don't know any who think that doing restoration in a jail is a good place to provide mental health treatment.

There's also significant issues with being able to not provide medication over

objection, training staff. We just don't think that this is a good appropriate place to provide restoration, yet every year it turns up in the budget. So we wanted to point that out.

The other piece that we're very concerned about, and we will be coming to you to discuss further, is an assumption in the budget that shifts the cost of competency restoration for someone who is in the care and the custody of the state commissioner of the Office of Mental Health, receiving treatment in a state-operated psychiatric center, to be returned to competency prior to going back to face a criminal justice procedure because they have been restored such that they understand the charges against them and can advocate on their own behalf.

In current years, the state has charged the county 50 percent of a per-diem rate for 730 competency restoration. This would do a shift so now the counties would pay 100 percent of the daily cost per person for competency restoration. Outside of

New York State, we're looking at 12 million.

I can tell you that there's no planning that a county could do for the cost of restoration. You could go four years without a 730, and then you've got six 730s in one year and it costs you hundreds of thousands of dollars -- or millions, in some counties. So we -- and this money goes into the General Fund. I think that's important to point out.

So thank you very much for your time, and we'll be visiting you later.

CHAIRWOMAN WEINSTEIN: I'm going to ask a question about what you just said. So you heard the commissioner respond to questions about this topic of the local jail restoration. And I guess what I'm hearing from you is you don't agree.

She was saying that people could be treated in the local jail, which would be reasonable to the county than having them treated in a hospital setting. But you seem to say both that that's not an appropriate setting and that the costs are greater than

what she's saying.

MS. HANSEN: You are correct, Chairwoman. I think there was a lot of confusion in the discussion between jail-based competency restoration and allowing counties to do jail-based -- keep in mind, this is an individual who's been charged with a crime, generally felony level, who's been evaluated and deemed incompetent to go forward in the judicial proceedings because they have a mental illness and have been deemed to not understand the charges against them and not able to aid in their own defense.

So under law, that individual is then transferred into the care and custody of the commissioner of the Office of Mental Health, and they are then treated at a state psychiatric forensic center -- Kirby, some of the others -- until they are restored to competency, and then they would come back.

So the first piece is the jail-based restoration, which is -- I don't agree that it's a fiscal benefit to the counties. And

from the clinical standpoint, my members would tell you that they don't agree that the jail is a good place to provide mental health treatment.

The other piece is on what has currently gone forward with the cost of the 730 -- same thing, 730 Criminal Procedure Law -- for the competency restorations, where the counties have traditionally been charged 50 percent of the per-diem cost for a 730 -- all of which that money goes into the General Fund -- and now that would be shifted to the counties paying 100 percent of the cost.

New York City apparently started paying 100 percent of the cost last year, and it's millions of dollars. And we're trying to find the justification as to why this is a county cost as well.

CHAIRWOMAN WEINSTEIN: Thank you.

Senator Carlucci.

SENATOR CARLUCCI: Thank you, Director Hansen. And thanks for coming to our committee and giving us an overview, to the Senate, of what some of the priorities are

and what you're working on.

And to follow up on the jail-based restoration program, the shift is something that we're all very concerned about in that cost, and what it just means to the locality. And do you have an idea from your estimate of what -- for the local mental hygiene directors, what that cost shift will be for the rest of the State of New York outside of New York City?

MS. HANSEN: We're told that, fully annualized, about $12 million.

SENATOR CARLUCCI: Okay, $12 million. So it's right now -- just so I understand it correctly, it's probably about $24 million annually, and the county gets reimbursed half of that?

MS. HANSEN: No, it's -- we reimburse 6 million. Rest of state, the cost is 12 million. That would be the shift to 100 percent for the county. And New York City is separate.

SENATOR CARLUCCI: Okay. So right now, under your calculation, it would be --

if it stayed the same as last year, on average, it would be about a $6 million increase to the counties.

MS. HANSEN: Correct.

SENATOR CARLUCCI: Okay. Thank you.

MS. HANSEN: That's my estimate, I guess.

SENATOR CARLUCCI: Okay. And last year the Governor did put in $850,000 to incentivize counties to take on this challenge. And could you just elaborate a little bit more how -- you did make the statement that you didn't think that that's an appropriate place to get treatment.

Could you just tell us about your reasoning?

MS. HANSEN: Certainly. Thank you.

And, you know, based on what I -- my -- our commissioners' discussions, you know, I think -- if someone is deemed incompetent, they have a severe mental illness, a pretty high diagnosis. And I don't know how much time you've spent in jails lately; I spent a lot with our SUD

project. And to put staffing in a jail -- you need clinical staff, not COs. Clinical staff. And it's not a therapeutic place by any stretch of the imagination.

The other piece is for a number of individuals, being started on a medication regimen is extremely important to starting to treat a serious mental illness. The jails cannot medicate over objection without going to court, and that takes away one of the very significant tools that would need to be in place in order to do jail-based restoration if any county wanted to do that.

I know other states have done it. I don't see a lot of uptake from our members that would think that this is a good placement. And I also don't think that, by having the counties pay 100 percent of the cost, that that provides any change in the therapeutic discussion or that all of a sudden people will want to do jail-based restoration.

SENATOR CARLUCCI: Okay, thank you.

MS. HANSEN: Thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

Assemblywoman Rosenthal.

ASSEMBLYWOMAN ROSENTHAL: Thank you.

Hi, good to see you.

MS. HANSEN: Great seeing you.

ASSEMBLYWOMAN ROSENTHAL: So last year we worked closely together, and left on the floor was my medication-assisted treatment bill, which I hope to get to pass this year.

How much money do you really think would be necessary in order to accomplish what we're trying to do?

MS. HANSEN: There's a couple of different factors. Number one is, again, we don't have a visual yet into what the jail census will be. And keep in mind that someone's jail stay is generally anywhere from 14 to maybe 20 to, outliers, 40 days. So we're working with folks in a relatively short timeline.

But the N, the number of individuals in jail, is in part what drives what we put together as a fiscal assumption.

For the medication-assisted treatment

bill, we issued and shared with you and others a fiscal impact that took a very conservative approach and said that at any given time in the county jail system outside of New York City, individuals -- you'd have 50 individuals on Vivitrol, 50 individuals on methadone, 50 individuals on Suboxone, and 50 individuals on Sublocade.

And as you know, the cost of these medications is significant. And in addition to the cost is having the waiver prescribers, the clinical piece around it. And you mentioned, Assemblywoman, that medication-assisted treatment is the medication and the clinical piece together, it's all together. I sometimes think that gets lost in the discussion.

So our concern was the cost, with how do you build these programs? And what we're saying is continue to fund our counties to be able to develop the counseling, the behavioral health services that are needed in order to overlay a medication-assisted treatment program. because we're not there

yet. We've made great progress, with your support and funding, but we have more to go.

So that was what our position was in terms of let's continue building services in the jails so we can help people in those 14 to 22 days, and have transition services in place for a good, solid reentry into the community.

ASSEMBLYWOMAN ROSENTHAL: Are the -- the supply of Vivitrol, is that part of an agreement with the company that makes Vivitrol?

MS. HANSEN: I don't know. I mean, I think that's more a sheriff discussion. I think it was the first one that was, you know, available on the market. It's injectable, and certainly that's a consideration as well. I mean, Sublocade is injectable now too, as things have changed.

ASSEMBLYWOMAN ROSENTHAL: Right. Right. Right.

But would you call it a good investment? You know, we're going to try to unearth that money. You call it a good

investment toward getting people back on the right path.

MS. HANSEN: I think any money to the county mental health commissioners that would allow us to expand treatment and transition services in the jails is a good idea for all individuals.

ASSEMBLYWOMAN ROSENTHAL: Thank you.

CHAIRWOMAN WEINSTEIN: Thank you. Thank you for being here.

MS. HANSEN: Thank you.

CHAIRWOMAN WEINSTEIN: Next, Substance Abuse Providers in Schools, Kevin Allen, chair, Local 372. And Donna Tilghman, secretary. Thank you.

MR. ALLEN: Good afternoon. To the chairperson, to the distinguished members, how's everyone? My name is Kevin Allen. Along with Donna Tilghman, we represent 275 substance abuse or prevention and intervention specialists of the New York City Department of Education, Local 372 with DC 37.

You have the information in front of

you, but I just want to make it personal so it would resonate. The SAPIS is the only person in the school that works a 12-month year. As opposed to guidance counselors, as opposed to various teachers that have grades K-12, SAPIS have all grades, kindergarten through 12th grade. They also deal with students from A to Z.

They also are the only people in the building that deal with an evidence-based curriculum that we teach. And it's across the board, all over New York City. Life skills, Second Step, Too Good For Violence, Too Good For Drugs, are just examples of evidence-based curriculum that OASAS has okayed, along with the Department of Education, for us to show fidelity throughout no matter what borough, what school you go into, SAPIS will be teaching out of this curriculum.

We are here asking for a joint legislative appropriation of 2 million plus -- 2 million from the Assembly, 2 million from the Senate.

As any successful corporation, any successful organization, there's two things that are always important to them. One is scalability, and the other one is scalability. To sustain and to build. And so we're at the point where we are glad that we have dedicated SAPIS, but we want to be able to keep who we have and to be able to build on their reputation and build on their success that they've already built.

They do classroom presentations, they do positive alternatives, they meet with parents, they meet with communities. Because of the new vaping, we are doing vaping demon -- we're talking about vaping from another perspective where we already have established DVDs on that and we're bringing more parental and more community awareness to that.

As our commissioner had just come to speak about, there is more than ever before a direct correlation between substance abuse and mental health. And we see that going down from our high schools to our middle schools and to our elementary students. And

what we want to do is give them as much information, give them as much of a foundation to be able to change the course of a child's achievement from kindergarten to the 12th grade.

We are excited about that, and we're asking for the -- for both the Assembly and the Senate to each contribute $2 million towards SAPIS in this year's budget, for a shared allocation of $4 million in funding.

All together, this would preserve and create the equivalent to at least 48 full-time SAPIS positions, and the potential to reach up to 24,000-plus students and their families who would otherwise not have the support that they need.

We just don't want to be driven on data, but we want to be also driven on results. And as we go into each and every school, each and every school has several things that are in common. They all have their own culture, their own climate, and their own community and language. And because of all of these things, we see that

it's more necessary than ever before to bring home the message of this.

One additional thing that a SAPIS does that no one else has, the way that we do it is that we have built our social-emotional needs in these lessons. If there's 15 lessons and life skills curriculum, and if there's 13 lessons and a Second Step, 85 percent of those lessons are based on social-emotional. Which means that we want to get to the root of the matter.

I thank you for listening, and if there's any questions, please feel free to ask.

CHAIRWOMAN WEINSTEIN: Senator Liu for a question.

SENATOR LIU: Thank you, Madam Chair.

Not so much a question, I just wanted to thank Mr. Allen and his colleague. They are leaders at Local 372 who really are instrumental. I mean, honestly, when we talk about schools, we -- when we're thinking about schools, we talk about teachers, principals. We often forget the other staff

that rounds out the education and the care for our kids.

So thank you and your members for all the work that you do. And I certainly will support this.

MR. ALLEN: Thank you, Senator.

CHAIRWOMAN WEINSTEIN: Assemblywoman Rosenthal.

ASSEMBLYWOMAN ROSENTHAL: Hi.

I too would like to commend all the good work that you do in schools. And the Assembly for years have provided $2 million in extra funding for you, which I hope this year we can -- each house can provide $2 million, that's my goal.

I wonder if you could just expand on how, if you got this increased funding -- right now you have 270 people working in the schools, right?

MR. ALLEN: Yes.

ASSEMBLYWOMAN ROSENTHAL: And how many more could you get if we increased the funding?

MR. ALLEN: We would go to at least 24

to 50 more additional people, 48 full-time. Which means that if there's 1700 schools in the New York City Department of Education, it would be even that more that we'll be able to get at any point.

And that means even with the point of having a SAPIS collocated in different schools, which we have in some situations, we can fill that need more prevalent than is happening.

ASSEMBLYWOMAN ROSENTHAL: I mean, one of the key elements everyone talks about is prevention, education and then, of course, treatment and recovery. But if we don't do the first two points, we're not -- you know, we're going to keep going down a bad road.

So I think your work is essential. And I know you have included vaping now, because that is also --

MR. ALLEN: Yes, we have.

ASSEMBLYWOMAN ROSENTHAL: -- something all the kids are doing, unfortunately, in schools. But I think your model is great, and continue to do the great work you do.

Thank you.

MR. ALLEN: And I thank you for your support.

And we've seen, more than ever before -- it seems that every other week there's another vaping fatality. And we take that to heart. And the information that we're able to give each and every student, which gives to each and every family, that gives to each and every community, that gives to each and every city, that's what we want to circumvent, that type of thing.

Because we're talking about -- the new word is the "C" word, contemporary issues. These are issues that maybe 15 or 20 years ago, we did not see as rampant as we see now in our elementary, middle school and high school students. So we want to be right on the cutting edge in regards to this.

ASSEMBLYWOMAN ROSENTHAL: Okay. Thank you.

MR. ALLEN: Thank you.

CHAIRWOMAN WEINSTEIN: Thank you for being here. And again, thank you for the

work your members do in the city schools.

MR. ALLEN: Thank you, Chairperson.

CHAIRWOMAN WEINSTEIN: Next, Friends of Recovery-New York: Angelia Smith-Wilson, executive director; Allison Weingarten, director of policy.

And if you're keeping score, after this will be research for a Safer New York, then Legal Action Center, then The Arc New York.

MS. SMITH-WILSON: Good afternoon. I am Angelia Smith-Wilson, the executive director of Friends of Recovery-New York. Friends of Recovery-New York is the only statewide recovery organization in New York State, and we represent the voice of individuals and families living in recovery from addiction, families who have lost a family member, or people who have been otherwise impacted from addiction. I myself am a family member in recovery.

In New York State there are over 260,000 admissions annually. These admissions make up crisis and noncrisis

admissions to treatment facilities. We know that those folks that enter a treatment facility will leave that treatment facility and reenter their community. So it is important that we keep at the front of any discussions around addiction and addressing the opioid crisis. When we talk about treatment, we cannot miss talking about recovery, because recovery wraps itself around and supports people as they leave treatment. It supports the treatment itself.

So fortunately since 2017, recovery-oriented systems of care, which include the development of recovery community organizations, recovery community outreach centers, recovery youth clubhouses, peer engagement specialists, family support navigators -- these services, combined, have touched over 250,000 individuals, saving lives to no doubt mitigate the overdose crisis that we are currently in.

We respectfully ask you to further continually consider recovery in your discussions when you discuss being effective

at addressing the current opioid drug crisis, as without adequate funding, as we have heard today, as you have pointed out today, treatment services will not be fully supported if you are not supporting recovery services. So more funding is needed.

We would ask that any proceeds coming from the opioid settlement dollars -- which we estimate could be as high as $1 billion -- to be directed to evidence-based prevention, treatment and recovery services, as these dollars in particular, $40 million of them, are needed to further ensure that one recovery community organization, one recovery community outreach center, one recovery youth clubhouse, two peer engagement specialists, two family support navigators, can and will be in every county throughout New York State.

So in addition, we are very much in tune -- in light of the sign of the times in increasing access to substances, we are very concerned about our youth. So Allison will talk about that point.

MS. WEINGARTEN: Thanks, Angelia.

And I would like to just say that I work very closely with a group called Youth Voices Matter in New York State, and they are under the Friends of Recovery organization. And there are currently three young people employed in Western New York, New York City, and the Capital Region, to go out and find young people and support recovery.

And if we're talking about a continuum of care, we like to say that prevention is recovery, especially for young people. So that we are providing these services so that young people don't feel like they're alone.

So that is federally funded, and we are definitely looking for your support, especially over the next year, to try and get that embedded in the state budget.

And I want to say that that program is being recognized federally. Angelia attended a conference last summer, a national conference, and that New York State program was getting that kind of credit. So we want to definitely see that continue.

Thank you so much.

MS. SMITH-WILSON: Thank you.

CHAIRWOMAN WEINSTEIN: Thank you for being here.

Senator Carlucci.

SENATOR CARLUCCI: Thank you, Chair.

And thank you both for being here today. Director Smith-Wilson, Angelia, good to see you again.

And I just want to thank you for your commitment to our community. I know we have a very strong group in Rockland and Westchester Counties with Friends of Recovery, and it's been tremendous. So thank you for your commitment. You've risen to the occasion, and it's just been tremendous.

We've talked a lot today about so many different issues which you are -- you're involved in each of them, pretty much, when it comes to addiction. And I was questioning the commissioner earlier today about some of the barriers. And you list out, and you do a great job of that, about what is needed and, with the right funding, the services you'll be able to provide.

I wanted to ask you about some of the direct obstacles that you see to access to medical-assisted treatment, but particularly to methadone. When I was asking the commissioner, the commissioner didn't want to comment on anything related to Medicaid.

Would you be able to tell us what you've seen in terms of access to methadone, any of the major roadblocks, or suggestions that you see that we could be doing to make it easier to access that type of treatment?

MS. SMITH-WILSON: Well, I think as the commissioner kind of touched on, it is a very complicated issue with regards to having individuals be able to bridge certain scrips when they leave. And because of all of the issues that are tied with Medicaid, it becomes a complicated issue.

And I think for our folks, we just simply want, to be honest, for you guys to figure it out. Because our folks are the ones that are leaving treatment facilities, jails or outpatient or even at the ED, our folks are the folks that are leaving and not

having the medicines that they need.

And so we have tried to support in any way that we can by providing testimony from individuals, by collecting data. We do a lot of surveys, and anytime there's any issue that our community is facing, we will put together a survey to really collect that data and to really be able to drill down and apply recommendations that the community has kind of validated and authenticated and that is real, that is happening for them on a daily basis.

And so I would say that it is a complicated issue, one that we are hopeful that in the coming years we can begin to really kind of mitigate. And folks will have the necessary medications that they need as they leave facilities.

SENATOR CARLUCCI: Okay, thank you.

I was going to ask -- I know we're out of time, but we'll talk further about it -- but the access to supportive housing and the barriers that are there.

MS. SMITH-WILSON: Oh, yes, that

remains. That was a -- we did a survey at our recovery conference in October. Over 150 people were surveyed, and that was at the top of our list.

So Stand Up for Recovery Day, we will definitely be talking about housing.

MS. WEINGARTEN: Yup. Tuesday, February 11th, I know many of you are going to be there. So we're excited to have you there to listen to the voices of the people in recovery.

And thank you for all that you do. We want to work together, continue to work together.

CHAIRWOMAN WEINSTEIN: Thank you for being here today.

Next we have Legal Action Center, Christine Khaikin and -- Wendy Burch was before, so I assume that's not accurate.

MR. ROBINSON: What about Research for a Safer New York?

CHAIRWOMAN WEINSTEIN: Oh, I'm sorry. Research for a Safer New York. Please. Ken Robinson.

MR. ROBINSON: Thank you. I didn't want to miss my turn.

CHAIRWOMAN WEINSTEIN: Not to worry. It's the bright lights.

MR. ROBINSON: Good afternoon. As my written testimony indicates, my name is Ken Robinson, and I am the executive director of Research for a Safer New York.

Research for a Safer New York is a consortium of harm-reduction providers that has been established to oversee a pilot research study in the form of the operation of five overdose prevention centers in New York State, four in New York City and one in Ithaca. The 24-month pilot study will evaluate the efficacy of OPCs as a crucial strategy to prevent opioid overdose fatalities, reduce public drug use and needle sharing, create a pathway to substance use disorder treatment and recovery, and combat the HIV and hepatitis C epidemics.

Most of you probably know that overdose prevention centers are a safe and clean place where indigent IV drug users can

consume their drugs under the supervision of staff that have been trained to intervene with naloxone in the case of overdose.

OPCs started in Europe in the '70s, and they then spread to Australia and Canada. Multiple empirical studies have been done, and the data has been consistent and it has been clear: OPCs increase access to drug treatment and services.

They decrease crime and disorder. They reduce public injection and hazardous litter. They prevent HIV and hepatitis C transmission. And they are cost-effective. Studies indicate that they save the jurisdictions that they operate in millions of dollars by reductions in medical, criminal justice, incarceration, and public sanitation costs.

So this is my second year in a row to come before this body to ask you to authorize the Overdose Prevention Center Act. In the meantime, I have met with many of you and/or your staffs to essentially plead with you to support this initiative. Last year we tried

to get the OPC Act included in the budget; that failed. Then we tried to get a bill passed, but it never made it out of committee.

I have to tell you, my heart has become heavy, because people are dying. We're talking life and death here. I could have done an easy, quick calculation of the people who have died from the last time I testified to this time, but I didn't, but we all know it's a substantial number of people.

It really, truly, sincerely is beyond my comprehension that we cannot pass this simple piece of legislation, whose sole purpose is to save lives and to get a very vulnerable and hard-to-reach population into care. Saving human lives should not be controversial. Saving human lives should not be a crime.

Esteemed Senators and Assemblymembers, it is time for all of us to show moral and political courage. I know that this bill has negative stigma associated with it, but that is because people do not understand. Most

people are good and decent, and it is incumbent upon us to educate them. Passing this bill is simply the right thing to do, and we must do it.

A great example of the benefits of OPCs is the Insite program in Vancouver, Canada. Insite was the first OPC in North America, and it's one of the most well-known OPCs in the world. On their website they say that in 2017 they engaged in 1,983 overdose interventions and in 2018 they engaged in 1,466.

Last July I spoke with Insite's director, Elizabeth Holliday. I was curious, and I asked Ms. Holliday if she would say that each one of those interventions was a life saved. She emphatically replied that she knew with a high level of certainty that each of those of 3,449 interventions was a human life saved.

Think about that. That's 3,449 families that did not have to bury a son, daughter, brother or sister; 3,449 mothers that did not have to suffer the crushing

grief of losing a child.

Again, we must authorize the overdose prevention, we must authorize overdose prevention centers this session. One of the lives saved may very well be one of your friends or family members.

Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Senator David Carlucci.

SENATOR CARLUCCI: Thank you, Chair.

Thank you, Director Robinson.

MR. ROBINSON: You're welcome.

SENATOR CARLUCCI: I wanted you to elaborate on -- I'm going to ask you two things. First, what are some of the reasons you believe that this legislation has not been passed?

And we saw not too long ago, a few months ago, a federal judge rule down the Department of Justice's intervention in trying to strike down a nonprofit provider from doing safe -- overdose prevention in a facility in Philadelphia. And so they said, okay, well -- they were fighting and saying

that the Controlled Substance Act of 1986 precluded them from doing this. The federal judge said no, they can. Where does put us now?

And then also, because that roadblock, it seems to be pushed aside that, okay, we had -- it was against federal law, possibly, to do this. We see that that's not the case. Could you elaborate on that? And also, what are some of the other issues holding up this important legislation?

MR. ROBINSON: If it's okay, I'll back up even a little bit more and explain to everybody -- I know some of you know this story, but originally this was going to be done by executive order through the Health Department. The Governor was all in, he promised us that he was going to authorize this. We even saw a draft of the letter that they wrote to authorize it. And Commissioner Zucker, I understand, was holding that letter, just waiting for the Governor to say go ahead. The Governor said "However, I need to wait until after the

general election," which we understood, but then we never heard from him again. He just went away.

Interestingly, I had -- we had a meeting with his chief counsel, the first time we've talked to them at all since then, earlier today. There may be a glimmer of hope that that could happen. I'm not terribly optimistic about it.

So then we switched to the strategy of getting a bill passed, under the leadership of Assemblymember Rosenthal. And I would have to give credit to Senator Rivera too. We all worked really hard, I think, to get it passed last year. The political will just wasn't there, I guess, Senator Carlucci, that's the best thing I could say about it.

SENATOR CARLUCCI: Do you believe that the federal court's decision --

MR. ROBINSON: Oh, going back --

SENATOR CARLUCCI: Yeah.

MR. ROBINSON: Well, I have kept up quite a bit with the Philadelphia situation. Everybody knows that the judge ruled in favor

of Safehouse, and then the Justice Department pretty quickly said, We are going to appeal. Well, of course they are, we knew that they would do that.

Safehouse recently said: We're going to open anyway. We feel we have a stronger case in New York State, because they're doing that just on the authority of the City of Philadelphia. We would be doing it on the authority of the State of New York, who has the authority for an emergency -- we're in an opioid crisis, an epidemic. The state could recognize that as an official emergency, and we would have a much stronger case in court.

Through our discussion this morning, there were two or three lawyers in the room. We don't think that they could probably even get an injunction like they got in Philadelphia. That's what the people in the room said this morning.

SENATOR CARLUCCI: Okay, thank you.

MR. ROBINSON: You're welcome.

CHAIRWOMAN KRUEGER: Thank you.

Assembly.

CHAIRWOMAN WEINSTEIN: Assemblywoman Rosenthal.

ASSEMBLYWOMAN ROSENTHAL: Thank you.

Good to see you again.

Do you think the stigma around being a drug user is abating a bit?

MR. ROBINSON: I do. I certainly do. I think that that stigma -- you know, this just crushes my heart. You know, unfortunately, it seems to me people don't value their lives. That stigma is so strong that people just don't seem to care whether they die or not. You know, it breaks my heart.

I -- you know, a couple of people today have mentioned about making it personal. I'll make it a little bit personal for me. I'm in recovery, recently in December celebrated 20 years. I'm a former IV drug user. So I've got a passion, I've got a passion to get this done. And I know that stigma firsthand.

You know, I'm also a gay man of a certain age, and I saw the government turn

their back on us. And they didn't give a damn if we died or not either. And a lot, a lot of people died. Well, I'm seeing the same thing now, it seems like to me, with this group of people. It seems that -- like many -- many, certainly not everybody, but many in government are more worried about political considerations than they are whether or not these people live or die.

ASSEMBLYWOMAN ROSENTHAL: Well, I look forward to continuing our work together. I mean, it is an epidemic and it is a matter of life and death.

And it's hard for me to understand as well when overdose prevention sites have been legal around the world for years, and here in the United States and in the progressive State of New York, we can't take a step forward when we know it works in saving lives and providing treatment, housing, healthcare, et cetera, for people who need it.

MR. ROBINSON: Right. It's become the number-one entryway to treatment in Vancouver, the number-one portal in

Vancouver. We would see the same thing here, I'm sure.

ASSEMBLYWOMAN ROSENTHAL: Thank you.

CHAIRWOMAN KRUEGER: Thank you very much for your testimony here.

MR. ROBINSON: Thank you.

CHAIRWOMAN KRUEGER: Next up, Christine Khaikin, from the Legal Action Center, and then followed by -- if people want to get ready and come forward -- Mark van Voorst of The Arc New York, and then he will be followed by a panel of Lauri Cole and Andrea Smyth.

Good evening -- is it -- wait, afternoon, I take that back.

MS. KHAIKIN: Good afternoon. My name is Christine Khaikin. I'm a health policy attorney at the Legal Action Center. And we have a long history of working to remove barriers to health insurance coverage for people with substance use disorders and mental health needs, and so we thank you for the opportunity to provide input today.

You have my written testimony, so I'll

just focus on a couple of priorities.

Last year's passage of the behavioral health insurance parity reforms, a groundbreaking set of policies, made several advances towards improving the ability to access life-saving substance use disorder and mental health treatment. But New Yorkers still struggle to access life-saving addiction and mental health care.

For example, they have trouble finding providers with available appointments in their insurance networks, they face delays in getting care because their insurer requires prior authorization, or their care is denied midway through treatment because their insurer says their treatment is not medically necessary. People are paying hundreds or even thousands of dollars out of pocket when they have insurance, due to copays and coinsurance charged higher or more often for substance use disorder and mental health care than for medical care.

High-quality providers throughout the state are not accepting insurance or

struggling because they receive subpar reimbursement rates for behavioral health services compared to physical healthcare.

The state and federal parity laws have made things better, but insurers are still often not held accountable for violating the law. Insurance should help people access care, not prevent someone from receiving treatment.

That is why we were thrilled to see that the Executive Budget includes a proposal to require the Department of Financial Services and DOH to promulgate regulations to clarify and strengthen parity compliance requirements. These could provide strong compliance standards so that the regulators can hold plans accountable to follow the law and to not discriminate against people with substance use disorders or mental health service needs.

The Executive also proposes to establish the Behavioral Health Parity Compliance Fund, to collect penalties from plans who violate the law. And as we heard,

$1.5 million of those funds will eventually go to support New York's mental health and substance use disorder ombudsman program, known as CHAMP.

Thanks to the Legislature, in 2018 CHAMP became a first-in-the-nation ombudsman program. Operated by OASAS and OMH, CHAMP operates a helpline, run through the Community Service Society, as well as a current network of five community-based organizations that provide on-the-ground outreach and localized support and expertise. CHAMP has served over 1600 New Yorkers since it launched, and it helps people overcome many of the insurance barriers that I cited, as well as connects people to care.

While this fund will hopefully eventually provide support for CHAMP, there is a great need now for the Legislature to provide $1.5 million to supplement the current $1.5 million budget for CHAMP. The additional funding will allow a localized network of CBOs to expand to many more counties across the state -- we saw Senator

Harckham's map showing there are many bare counties -- and additional money will also help extend the helpline hours beyond a limited time during weekdays.

We were also grateful for the Legislature's support for removing prior authorization requirements for all FDA-approved medications to treat substance use disorder. And while we were thrilled to see the Governor sign legislation to remove prior authorization in commercial insurance, Medicaid recipients must also receive this benefit, because administrative barriers should not be getting in the way of receiving immediate life-saving care. And we thank the Legislature for your continued support to make this happen.

And I just want to thank you for the opportunity to provide input.

CHAIRWOMAN KRUEGER: Thank you.

Senate? Well, I have one quick one.

So you were here earlier when we were asking the OASAS commissioner questions. What's your opinion about what's preventing

the State of New York from just making sure people have continuation of Medicaid coverage from when they're leaving prison to when they get to communities? There seems to be such a disconnect in our inability to get this taken care of.

MS. KHAIKIN: Well, I think one of the issues there is the current inability to provide Medicaid inside the walls. And so DOH recently submitted a federal waiver to be allowed to provide Medicaid for the last 30 days while people are inside. And that would really help with that transitional care, because it would allow people to get enrolled and begin receiving transitional services even before they leave.

And so I think that waiver will be really important. Right now it's with the federal government, so we'll see what happens. But I think that that -- being able to start those transitional services and provide Medicaid inside is a great path forward for that.

CHAIRWOMAN KRUEGER: So when they're

inside they can get the drug, but you're suggesting that we need a federal waiver to start them a month in advance before they leave jail. But we could still do the application while they're in jail and literally turn it on the day they get out, right?

MS. KHAIKIN: Yes, correct. Yes.

CHAIRWOMAN KRUEGER: We wouldn't need a waiver for that.

MS. KHAIKIN: You would not need a waiver for that, that's right.

I don't know if I can speak to all of the reasons preventing that from happening right now, but I do think that that -- starting services and Medicaid before people leave would be great. And we'll see what happens with the waiver.

CHAIRWOMAN KRUEGER: Thank you.

Assembly? No. Thank you very much. Appreciate it.

MS. KHAIKIN: Thank you.

CHAIRWOMAN KRUEGER: Okay. And as I said, we now have Mark van Voorst, The Arc

New York, followed by a panel of two.

Good afternoon.

MR. GEIZER: Good afternoon. Thank you for the opportunity to speak with you today and provide feedback on the proposed Executive Budget, its impact on our field, and the people that we serve.

I am Erik Geizer. I'm one of the deputy executive directors. Mark van Voorst unfortunately could not be with us today due to illness.

The Arc New York represents 47 chapters across the state who deliver essential supports and services to New Yorkers with I/DD. We are the largest voluntary provider in our field. We support more than 60,000 individuals and families. And we employ almost 30,000 people throughout the state.

I've organized my talking points today into five distinct areas which are reflected also in our written testimony, but I'd like to just touch briefly on each of them.

The first is #3for5, which you've

heard several times today. The Arc New York has joined forces with the New York State disability advocates and the larger human services sector to request a 3 percent annual program funding investment every year for the next five years. This is the same #3for5 campaign you've heard today, sector-wide support.

Investment keeps pace with inflation, it's aligned with the overall growth of Medicaid funding that the Governor deemed reasonable and expected in his State of the State address.

New York has a legal and ethical obligation to provide essential services, quality care, and integration for its citizens with I/DD. Our shared responsibility to the people we support is non-negotiable.

The next area I'd like to just speak about is mergers and consolidations. While we appreciate the investment in our DSP workforce, a decade of deferred cost-of-living increases has left our system

in crisis. We believe the state is intentionally and systemically underfunding the system to drive consolidation.

In the first 65 years of our organization's existence, The Arc New York conducted a total of four mergers, one each decade. Yet eight mergers were completed in the last five years alone, and another five are planned by the end of 2021. A similar trajectory can be seen throughout the field.

If the state's goal is increased efficiency, consolidations should be planned, proactive and initiated prior to providers developing into a crisis where services are jeopardized. However, crisis consolidation will continue to escalate in response to the economic constraints our providers face, and OPWDD simply does not have the funds or the capacity at this time to handle the rapid increase in consolidations.

COLA deferral has saved the state $5 billion over the last decade. We request, respectfully, that $10 million in state share funding be reinvested from that savings to

support the cost of additional consolidations occurring in the upcoming year.

In addition to the current financial pressure on providers, the release of the Executive Budget has raised further concerns about cuts to program funding the system simply could not sustain.

Managed care. The 2020 Budget Briefing Book included language which clearly articulated that funds required to transition to a managed care environment would be covered by the global Medicaid budget. This year the briefing book is silent on the matter. This omission is deeply concerning for our organization.

Funding for the implementation and operation of managed care cannot come from the operating budgets of providers delivering supports and services to the people with I/DD, or from existing resources of the OPWDD system. Any attempt to do so will result in the creation of a financial crisis that will rapidly and irreparably damage the service system before any positive outcomes can be

derived from managed care.

Deferred rate action. On their budget briefing call, OPWDD indicated there is insufficient funding in the budget to fully fund provider costs moving forward, based on the most recent rates. We are grateful that OPWDD shifted funds to fully reimburse providers through July 2020. However, we have been told to expect a budget neutrality factor of less than 1 that will be applied in July, in an effort to recoup $30 million in state share funding.

In his testimony today, Commissioner Kastner indicated that the budget neutrality factor will cut all rate-rationalized programs by 2 percent, significantly more than we estimated. This cut would drive already strained providers to the brink and would escalate crisis mergers beyond the current unsustainable rate. We request that the $30 million be included in the Executive Budget to fully cover actual costs for the fiscal year.

Our organization wants to partner with

state leaders. But to do so, we must be informed, we must have clarity of direction necessary to plan thoughtfully and invest proactively in the future of our service system. Today I urge not only your investment, but your transparency. We have far more questions than clarity about the transition to managed care and the preparation and investment that will be necessary to transform our field.

We believe the state is driving the field towards consolidation, but we have no definitive picture of New York's plan for our service system or its expectations for providers. To be effective partners with the state in serving people with I/DD, we need the administration to be clear about its vision for the future of our field.

And lastly, we will work to identify solutions and be strong partners in achieving our shared goals. To do so effectively and to fulfill our mission and our responsibility to the people we serve, we need the state to clearly define the path forward.

CHAIRWOMAN KRUEGER: Thank you. Thank you very much for your testimony today.

MR. GEIZER: Thank you.

CHAIRWOMAN KRUEGER: Next up, Lauri Cole, executive director, New York State Council for Community Behavioral Healthcare, and Andrea Smyth, executive director, Coalition for Children's Behavioral Health.

MS. COLE: Good afternoon.

CHAIRWOMAN KRUEGER: Good afternoon.

MS. COLE: Good to see you all. Thank you for being here and staying in the game this afternoon.

My name is Lauri Cole. I'm the executive director of the New York State Council, as you've said. And just to put it on record, it's 20 years for me before this entity.

And in addition to being a membership association director representing mental health and substance abuse providers around the state, I'm also a family survivor, twice over in the last two years, both losses to the opioid epidemic.

Everything that I say here today and that you've heard before me is largely related to the -- everything that I see is through the lens of access to care. Without it, without adequate access and continuity to care for some of New York's most vulnerable people, we are nowhere.

There are two public health crises facing us right now with the epidemic, the opioid epidemic, and increasing rates of completed suicides in certain populations. Our workforce are like first responders at this point. They are essential staff and should be treated, in that regard, similarly to the way that emergency personnel are often treated.

At this point the trauma associated with working in a job as a direct care person who is face-to-face with clients who may be there one day and not there the next, is collective and it's fierce. And it's resulted in all kinds of disadvantages for our field and our sector as it relates to being able to recruit and retain staff.

Andrea and I are both part of the #3for5 coalition, and I'll tell you that it is an unprecedented group of individuals. And we are looking for something more than a COLA. It is not that we're not appreciative, but instead it is that roofs need repair, health insurance bills go up, all kinds of expenses that we cannot control go up every year, in addition to recruitment and retention issues, et cetera.

So while we appreciate the COLA, and we needed it, we need something more. We need an investment, an infusion of resources into our human services sector.

There is money to be had this year. I want to remind you of that. I try and do that every year. There is a whole lot of money potentially proposed through DSRIP, and you'll hear about and see that a coalition of advocates is looking for a set-aside of DSRIP funds for community-based organizations, where in the past in DSRIP 1.0, we got a smidgen of those dollars for the community-based care side.

In addition to that, we continue to urge you to take a look at the Healthcare Transformation Fund account. That is the fund where Centene-Fidelis and other formal business transaction monies go and where hospitals and nursing homes received a disbursement this past spring. We do not begrudge our colleagues that money, but by no means do we think -- the legislation, the statutory legislation does not stipulate that it is only for a portion of the healthcare sector.

Now, that account is controlled by the Governor, and we just urge you to look at it and perhaps to speak about it and perhaps even to advance legislation that would put you in the mix in terms of that discussion, because we need you as champions.

In addition, I'd like to just also point out to you that there's money related to settlements to come -- the opioid settlement being one, but not the only one. The Governor's proposal on parity compliance provides an opportunity for income where

there has not been before. I'm hoping some of you will ask me questions about the type of enforcement that's gone on to this point, both in the Medicaid and the commercial space, related to the implementation of Medicaid managed care in our sector. It's been 3 1/2 years, and there have not been very many violations.

So with that, I'll turn it over to Andrea, my colleague from the Children's Coalition.

MS. SMYTH: Hi. I'm executive director of the New York State Coalition for Children's Behavioral Health. My name is Andrea Smyth. I'm also going to run through five quick issues.

Thank you for asking questions about the children's behavioral health expansion. I think pursuant to the previous Arc testifier, you can't start up a program unless you invest in new services. And what you heard today was that on January 1st, our startup got cut by 11.5 percent. And yet people are promising that that startup, that

expansion, is what's going to address the lack of access to care.

And I don't see how you start up and grow a program without the available startup funds. And the startup funds were not on the streets long enough. And they were paid through each individual child that got services as an add-on to the rate, and we think less than 700 kids got the services.

So the startup funds to expand the children's behavioral health capacity were not paid out. They're being limited by the Medicaid global cap. We've got to figure out the auspice between this committee and the Medicaid committee and what we're going to do about the Medicaid global cap.

The reason why there isn't an expansion in children's and family treatment and support services is because the Medicaid global cap is suppressing what they said they're going to invest in new services to a very small number -- $15 million -- under the global cap. So even if they say we need $60 million to spend on children's behavioral

health services, they're only going to commit to $15 million. And they will commit to $15 million from now until we change the global cap, so.

As Lauri indicated, we also are joining all of the human services field to talk with you about #3for5 funding to help communities thrive. The COLA has not been consistently funding; you've all acknowledged that. But my organization doesn't believe that the patchwork of alternatives is long-term sustainable for the nonprofits. And so by investing in the community-based service system, this year, with the first year of a five-year commitment of 3 percent, we believe we'll get on the right foot.

I'm hoping that you will look to other tables to help us with our workforce problems. The Governor proposed last year $175 million in statewide workforce development initiatives. We hope that the human services chairs will look towards adding a new human services workforce initiative.

Specifically, one of the key reasons why people are dissatisfied with the low-paying human services jobs -- the second reason. Low-paying is the first dissatisfaction. The second reason is overwhelming paperwork.

And we think if you had a legislative roundtable that talked about how the human services field could use the robotic process automation to reduce paperwork, and you invested in our ability to train people to do that work and to come and work for us, that we would start to have some productivity improvements in the human services workforce.

So we really urge you to carefully take a look at that. We are going to apply under the existing workforce funds. We're working with UIPath and Gigster, nationally known social impact bond corporations, to put together the proposal. But if we do it, there won't be a way for other human services agencies to do it unless you do a human services workforce initiative.

We heard with interest that the

$350,000 from OASAS for loan forgiveness was announced today, and we think that's great. And I've spoken with Senator Harckham about the fact that doing loan forgiveness for addiction professionals joins the $3.9 million that's in the budget for Senator Pat McGee's loan forgiveness for nurses and $1.7 million, through Senator Savino, for the LCSW loan forgiveness program, $50,000 for the child welfare worker loan forgiveness program, zero for the children's mental health, licensed community mental health, licensed creative arts therapists, licensed marriage and family therapists.

It's okay if we want to do this all piecemeal. It's fine. I'll ask you for $250,000. I'll go out and get a philanthropic match to make it $500,000. I can't retain my clinicians who come out of graduate school with a six-year degree with $120,000 in loans at a $39,000 annual payment rate if I can't offer them loan forgiveness. It's vitally important that we address it for

all fields.

Last year Senator Carlucci and Assemblywoman Gunther put in a revision to a loan forgiveness program. But we ask you one way or the other to make sure it hits the children's mental health field.

CHAIRWOMAN WEINSTEIN: Assemblywoman Rosenthal.

ASSEMBLYWOMAN ROSENTHAL: Hi. Thank you. Thank you both.

I have a question for Ms. Cole. I'm interested about the availability of MAT prescribers across New York State. I know that there are not enough medical professionals who have the waiver and are allowed to prescribe.

So I wonder if you would talk about that and ways that we could increase the number so that more people would have availability.

MS. COLE: Thank you for asking that question.

It's a big state, and certainly there are qualified, ready physicians, medical

staff who are prescribing MAT. However, federal regulation combined with some turf issues in New York State around scope of practice create a volatile situation where we are not maximizing the workforce that is the most interested, the most ready, and the most motivated to provide MAT. And those would be people who currently are operating under caps, arbitrary caps due to federal requirements.

One of the ways we can solve this problem, particularly in areas of the state that are not in concentrated urban settings, but also in rural areas of the state, et cetera, would be to focus on what can we do to incentivize those individuals -- nurse practitioners, psychiatric nurse practitioners -- in order to want to do this.

This is not easy work. That's why there are probably lots of slots available in a doctor's practice that are not filled to the limit with clients who need MAT because perhaps some potential prescribers do not want to do this work. We need to identify,

recruit, retain individuals who do want to do it.

And in order to do that, we have to look at scope issues. We have to look at what we can do to be flexible around federal regulations, and we've begun that discussion. But access to care begins with access to appropriate medications.

ASSEMBLYWOMAN ROSENTHAL: Is it federal law that -- I mean, for example, are we allowed to say every physician should be able to prescribe bu?

MS. COLE: There's an educational component that they have to complete. And sometimes for a prescriber who -- or a potential prescriber who has a busy practice, that may not be desirable.

ASSEMBLYWOMAN ROSENTHAL: But it's not preempted by the federal government, is my question.

MS. COLE: There are preemptions around the number of clients you can carry on a caseload.

ASSEMBLYWOMAN ROSENTHAL: Right. But

not how many people can write a prescription.

MS. COLE: I don't believe so.

ASSEMBLYWOMAN ROSENTHAL: Okay. Well, I'd love to work with you on that.

MS. COLE: Thank you.

ASSEMBLYWOMAN ROSENTHAL: Thank you.

CHAIRWOMAN KRUEGER: Thank you both very much. Appreciate it.

MS. SMYTH: Thank you.

ASSEMBLYWOMAN GUNTHER: I think I have one.

Could you shed some light on the disparity in rates between commercial and Medicaid and what they pay?

MS. COLE: Yes.

ASSEMBLYWOMAN GUNTHER: The other thing I thought when you were just talking about physicians, there's a lot of physicians that -- you know, it's a tedious practice when you do MAT, medication- assisted treatment, and a lot of doctors still had in their mind this picture of those that take drugs. They don't realize it's the stockbroker with the suit on and those kinds

of things. So it's about -- it's a stigma issue a lot of times.

MS. COLE: That's right. That's right.

ASSEMBLYWOMAN GUNTHER: And I think that -- you know, I know that in my -- kind of my own research, people travel miles and hours away to pick up their methadone in the morning because they don't want to be seen walking in and out.

However, if it were some simple doctor that -- or not a simple doctor, but a doctor that had all kinds of things going on, you wouldn't have to charge in error because no one would know your business, for instance.

MS. COLE: Yes.

I'll just tell you, as a partner in the state's ombuds program, we spend an awful lot of time watching people travel great distances to access care. And that's why the proposal that Christine spoke about earlier that would fund the ombuds program beyond the initial 1.5 is so important, because in your communities around the state, probably most

of you do not have community-based organizations that are set up and that are working with the ombuds program to provide local coverage.

ASSEMBLYWOMAN GUNTHER: And they work in silos also.

MS. COLE: That's right. That's right.

But to your question about commercial versus Medicaid rates, we've testified for close to a decade, the council has, that unlike other areas of the healthcare sector, in the behavioral health sector it is the Medicaid rate, the Medicaid managed care rate, that is consistent, stable and government actuarially set. Okay? That is called an APG government rate.

On the commercial side, over the last 10 years the New York State Council has asked the Department of Financial Services over and over and over again to take responsibility for the inadequate rates that commercial payers -- that is, private health plans -- are permitted to pay that are not in any way

near cost of care, let alone the Medicaid rates which the state has set.

And so what is created is a disparate system in which, interestingly, people with private health insurance, with commercial health plans, people who are underinsured, working-class people every day struggle to find access to care in those same clinics, with the same staff, with the same provider as a person who would show up at the clinic with a Medicaid card in his hand.

It is incredible. The state continues to permit it. What we've asked the Department of Financial Services to do is to take responsibility and seek statutory purview to set actuarially sound commercial rates so that we do not have this disparity in rates between commercial clients and Medicaid clients.

CHAIRWOMAN KRUEGER: Thank you very much, both of you.

MS. COLE: Thank you.

CHAIRWOMAN KRUEGER: Next up, New York Disability Advocates, Susan Constantino, and

I believe New York Alliance for Inclusion & Innovation, Michael Seereiter. And there was a third, but they did not submit testimony, so I'm double-checking, Yvette Watts and the New York Association of Emerging & Multicultural Providers as well. Did we get testimony from Yvette Watts? Yes.

MS. WATTS: Good afternoon, Chairwomen Krueger and Weinstein, Senator Carlucci, Assemblymember Gunther and other members of the Senate and Assembly. Thank you.

My name is Yvette Watts, and I'm the executive director of the New York Association of Emerging & Multicultural Providers. But the title that I'm most proud of is I'm a parent of a 34-year-old woman with autism, who still lives at home with me because of the wonderful services and supports that I received in the span of her life from the volunteer agencies downstate.

And I'm able to be here today because of the wonderful services that the DSP is providing for me right now. So thank you.

I'm here with my colleagues Susan

Constantino from -- she's the CEO of UCP of New York State {sic} -- and Michael Seereiter. He is the president and CEO of the New York Alliance. We speak to you today not as executives of our individual agencies, but as representatives of the New York Disability Advocates -- that's NYDA -- a newly formed coalition of more than 300 volunteer providers who are instrumental in delivering services and support to over 140,000 New Yorkers with I/DD.

While we've come to you independently for years to advocate for the field and for people we serve, today we come as one. Our members hold various perspectives and priorities on some matters, but our single driving goal is shared: The sustainability of comprehensive quality supports and services for New Yorkers with I/DD.

Across the state these organizations and the more than 120,000 people they employ provide lifelong, comprehensive, individualized services to support people with I/DD in all areas of their lives. In

addition to delivering physical and behavioral health services, they assist with transportation, housing, medication administration, cooking, feeding, developing personal care, community living, employment, and other crucial services.

As part of the broad coalition of over 40 associations across the human services sector, we are here today to ask the state to facilitate the continuation of this care and to stabilize the non-for-profit sector by providing a 3 percent increase in investment annually for the next five years. We're asking for #3for5.

We understand the state is facing financial headwinds. However, achieving #3for5 is crucial for ensuring continual care for New Yorkers throughout the state with I/DD. Right now crucial services are in jeopardy. Over the last decade, provider organizations have received only one cost-of-living funding increase -- that's less than .02 percent -- and have experienced $2.6 billion in cuts, pushing many provider

agencies to the brink of insolvency.

In a statewide survey that we conducted, nearly half of them have less than 40 days of cash in hand. A third of the providers reported having to reduce services or cut programs completely in the last three years due to funding constraints, impacting almost 50,000 New Yorkers with I/DD and more than 30,000 employees who support these individuals. And all over New York, providers are operating with minimal or outdated technology and deteriorating infrastructure. This is really dangerous.

Stagnant funding also affects employment. Provider organizations employ more than 120,000 people across the state. The majority of them are women and minorities. Many of these organizations are the largest employers in their counties, playing a vital role in the local economies.

Organizations are doing what they can to operate within these constraints, and they've taken a variety of steps to lower their costs, with four out of five having to

slash employee benefits to these already underfunded individuals. Yet they are running out of options and simply cannot continue to do more with less.

These communities deserve the same access to quality care as every other New Yorker. They deserve opportunities to lead independent, fulfilling lives and participate in their communities. We and I implore you to champion the lives of people with I/DD and to commit to support an annual 3 percent investment for the next five years.

CHAIRWOMAN KRUEGER: Thank you.

MS. CONSTANTINO: Thank you. I'm Susan Constantino, and I am here just to represent the New York Disability Advocates.

What I really wanted to do was just to give you a little more information about what these providers are going through. What we had done is in December we did a survey. And currently right now, as Yvette has said, there's 300 providers in the intellectual and developmental disability area. You heard everyone today talking in the whole human

service coalition, but I just have the information on the I/DD providers.

The providers that we surveyed have really been in their communities for 30, 40, 50 years or more. These are agencies that are viable, have always been viable agencies providing support to individuals and their families. But all of a sudden this is not what's going on any longer.

As Yvette stated, and we'll go just a little bit deeper, 50 percent of the providers statewide have less than 40 days of cash on hand. Your auditors will tell you that's not a good thing. However, 30 percent of the providers have less than 30 days of cash on hand, and we do know that there are providers that may have 10 days of cash on hand or less.

So because #bFair2DirectCare gave us dollars to increase salaries, those dollars came in and went right back out to those employees every single time, but not to the agencies so that we could help their structure.

Fifteen percent of our providers indicate that in the current years that they have used up to 75 percent of their lines of credit, the balance on their lines of credit. Some might have $2 million, some might have $15 million, depending on the size of the agency. It doesn't matter -- bigger agency, bigger bills. So they are using those dollars up.

And also, which I think is really one of the real critical things that is such a shame in all of this, is that in the last three years the agencies tell us that they've had to either reduce or eliminate programs. They have vacancies in their programs, vacancies that should be filled by people in the community waiting to come in. But they can't bring them in because many of these people who are referred to them have complex needs, complex behavioral needs or complex medical needs. And they would have to put on more staff in order to be able to accommodate them, and they don't have the dollars to do that. So those folks are not getting the

service that they need.

Years ago, those of us who are old and have been in this field a long time remember what the nonprofits offered to individuals, to our staff, was good benefits. We may not have always been the highest-paid in the community, but we offered good benefits.

That's not the case any longer. And over the last two years, what people have had to do is restructure their benefits so that people often -- your employees have to pay more than what they've paid before. They've reduced and restructured their retirement plans so that it's harder for individuals to make it on retirement. And many have had to reduce and/or close programs because they just can't afford what it costs to keep that program running. And, again, all critical services to families that are now being lost to us.

What individuals -- what they've told us is that, you know, they have had to really -- and I heard this question earlier -- they've had to really look very

carefully at what they do with their own facilities. Can they make all of the repairs that their facilities need, can they afford to put on the roofs, can they afford to do many things. The funding streams are not what they used to be, and those are also very significant issues to us in our communities.

They've had to switch vendors, not worrying about quality but worrying about cost, which is not always the best thing to do. And for many of them, they've had to reduce program staffing needs. Now, we all know that one of our main directives is always community inclusion, that's what we need to do. But if we don't have enough staff, and the staff because we've not been able to pay them, then we're not able to do that.

So I think -- and within there, and we've totally been appreciative of the -- all of the money that came with #bFair2DirectCare. But there are other people who work for us, vital people -- our payroll people, our human resources people,

any of our administrative people and secretaries that have been very difficult for us to be able to support any kinds of increases for them -- that's something that a COLA would be able to do.

So I guess what I'm saying is that the #3for5 is critical to us right now. This is the only way we're going to be able to keep on. And we are a much better deal than the state. So we are asking you please to consider this.

CHAIRWOMAN KRUEGER: Thank you.

MR. SEEREITER: Good afternoon. I'm Michael Seereiter of the New York Alliance for Inclusion & Innovation. Thank you.

I'd like to start with a thank you to you for your ongoing support and the support from the Governor for our workforce, which is really the backbone of the I/DD industry and the sector. We're very pleased to see the increase for the #bFair2DirectCare campaign and the effort, reflected in the Governor's budget, for a 2 percent increase this year taking effect on April 1st.

I would say that wages, I think, are only part of that equation, however. I think that another piece of that puzzle to address what is a huge workforce challenge for our sector is also a credential. And we would support -- we would urge resources to be supportive of the piece of legislation sponsored by Senator Carlucci and Assemblymember Gunther related to a DSP pilot.

I would like to quickly address something the commissioner addressed earlier, speaking around DSP wages and the fact that New York State enjoys DSP wages that are typically higher than most other states. I think the question really needs to be asked about what is the cost of living in New York State as it relates to those wages. And furthermore, what is the value of the supports and services the direct support professionals provide? I would argue it is not minimum wage work.

So we are indeed pivoting our advocacy efforts, and we're very pleased to be working

with the New York State Disability Advocates and the larger #3for5 campaign for the 3 percent increase each year for five years, as my colleagues here have more eloquently articulated today than I will. I will say three quick things about this.

Number one, the flexible resources we seek would do three things. One, it would stabilize the sector. Number two, it would provide the opportunity for provider organizations that operate in the sector to be planful about their futures. And lastly, it would actually allow us to continue the workforce investments that began under the #bFair2DirectCare campaign.

One of the things that -- well, another thing that Commissioner Kastner articulated earlier was that the cost-based methodology that currently is the methodology by which provider organizations are funded in this sector is probably the most favorable of any of the structures. I would say that that's probably true. However, that's not necessarily true when you artificially

suppress those rates with a budget neutrality factor or other across-the-board reductions like those that were articulated today.

So the rates are indeed less than what it costs to provide services. And just as a kind of -- in passing, those are rates that are reflected two years after the services are delivered. And again, they have not been reflective of any of the cost-of-living adjustments that this sector needs and has not been privy to over a period of about a decade now.

On the Medicaid Redesign Team No. 2, we're watching this very carefully and cautiously. We would encourage you to do the same. There seems to be no reason that this process can't improve on the previous process of the MRT 1 in three particular areas: Number one being improved representation for the populations that are impacted; number two being improved stakeholder input; and number three being an improved opportunity for reviewing the recommendations that are ultimately put forward.

Lastly, on managed care, we heard today and we've heard through the Governor's budget proposal that the SIP-PL plan qualification document is expected shortly. If indeed the I/DD sector is to continue to move toward managed care, it needs, I believe, four things: Number one, a continued investment in readiness resources, including the managed care community of practice that Senator Seward was asking about earlier, which is a project of the New York Alliance.

I will say two things about the managed care community of practice. One is that we are beginning the work to specifically try to address some of the itch points, the concerns related to the CCO implementation, and we are happily taking up some of that work, which will be starting with an inclusive conversation of everyone, all stakeholders involved in the system.

Number two, I would say that very shortly we will be delivering to your offices a white paper that discusses the implications

for New York State, based on a study of five other states that have already implemented managed care for the I/DD sector, and what can be learned from those experiences.

The second on my list of things that are necessary for success in managed care are investments in health information technology to be able to operate in a managed care structure.

Number three would be an I/DD ombudsperson program specifically geared for the specific needs of this population. It is a very different population than all of the other populations that have moved to managed care.

And lastly, I will quote from the Transformation Panel recommendations from now five -- I believe it was five years ago -- to, quote, identify funding to meet the administrative costs of managed care, distinct from funding required to meet the needs of individuals for services.

Under no means can the resources necessary to stand up that system come out of

the existing system provider sector or, by any means, out of those services and supports that individuals and families rely on on a day-to-day basis.

Thank you.

CHAIRWOMAN KRUEGER: Thank you.

Senator Carlucci.

SENATOR CARLUCCI: Well, thank you for your testimony and thank all of you for your commitment to protecting our most vulnerable populations. I share the concerns that all of you addressed today, and I think many of our colleagues do as well.

I just wanted to ask you to elaborate more upon -- because we didn't get time to talk about it today -- about the credentialing program, how you see that working and how it will help to give a better experience to the people that are being served.

MR. SEEREITER: Several years ago the Legislature appropriated funds to study this program -- study this idea in its totality. And the recommendations that came out of that

report really talk about how the credential needs to be accompanied by what is already in the existing system when we talk about core competencies.

That's kind of the base, right? And then on top of that you want to start to strive for excellence. And between the two of those things, you start to actually move a system toward identifying those opportunities for improving quality.

Quality is a definition that I think -- the definition of quality in this sector is something that is not yet fully defined. In fact, I think we're in the process of that right now.

If we are to be playing a role in helping to make that a -- helping to define what that is and certainly improving the lives of individuals with disabilities that these services and supports are designed to do, we need to be striving for that excellence.

And in doing so, the credential starts to push the system and it starts to create

the opportunities for people who want to be a direct support professional to do this and to make it a career, which is really where I think the secret sauce is. It's in the relationship between the individual served and the person providing those services. The longevity of that relationship, the quality of that relationship drive so much of what we see in terms of the outcomes I think that are possible in this system.

SENATOR CARLUCCI: Thank you.

And I wanted to -- I just wanted to also thank you for your advocacy for the #3for5 campaign. It's so important that we get the funding into the system.

And also I want to thank you for bringing it to the attention that it was stated earlier that our DSPs are paid at a level top in the country compared to other states. And I think it's important that we remind everyone that we really can't be looking to other states. If we want to go backwards, maybe we'll do that, but we want to continue to go forward.

And New York is consistently seen as a leader in providing services to our most vulnerable populations, and I think we have to isolate ourselves from that and not look to go backwards but look to go forward and continue to be an example for other states to follow.

So I just want to thank you for bringing that point up and really correcting that statement that was said earlier. Thank you.

Thank you, Chair.

CHAIRWOMAN KRUEGER: Senator Jim Seward.

SENATOR SEWARD: Yes, one question for the panel. I know some of you have talked about this in general terms, but I wanted to get your assessment of the CCOs and the impact on services to those that need the services in the DD community.

MS. CONSTANTINO: I'll take one crack at it.

SENATOR SEWARD: I mean, how's it going, I guess is the --

MS. CONSTANTINO: You know, I think for it being a program that's not quite two years old, it's going well, considering what we did and how we totally did away with one whole piece of what we had come to rely on, which was our Medicaid service coordinators, and move to something different. So I think in that regard it's doing well.

I think -- and we did hear the commissioner talk today, and I was really glad to hear him say they are meeting weekly. Because we as providers have sent our concerns, because there still are concerns.

I think the hardest part is for the families. They were very used to a very close relationship with their service coordinators. Because the CCOs have had to -- they have larger geographic territories and they've had to change how they really have been able to assign people, people have had to get to know new folks. And they've had so much pressure to do the life plans that they probably haven't had as much time to really begin to integrate into people's

lives a little bit more.

But I think for being a new program, it's really moved along quite remarkably.

MR. SEEREITER: I would echo that, actually. I think, you know, when you look at the larger trajectory of implementing a system change of that magnitude -- you're now a year, 19 months into the process, roughly -- I think it has gone along quite well, all things considered.

I think there's just also a -- I think there are some fundamental issues that do need to be addressed with the existing -- kind of the system that we now have. We're now, again, 19 months into implementation. That's no longer part of the implementation period. But I think that there are expectations that are either unrealistic or don't match up with what the service system is now looking like.

I think it is an oversimplification to say that it is simply a shift of the Medicaid service coordination capacity from the previous process to the care coordination

structure. That is, it's different. It is a health home model. And the scope and magnitude of the responsibilities of the health home and the care managers who work for them are different than those that work for the Medicaid service coordinators.

So setting reasonable expectations and helping everyone understand what the roles and responsibilities are, I think we kind of need to go back and do a little bit of the going back to basics. And that's actually where we're going to try to focus some of our managed care efforts, managed care community and practice efforts, to try to help understand what is it that we can actually expect out of this process and what are reasonable expectations.

MS. WATTS: But I can say, as a parent and also as an association rep, that we as parents, we've always worked with OPWDD and the volunteer sector. We've worked very closely with them.

So yes, this -- as Susan did say -- was a tremendous leap for the families, but

they are resilient. And I will tell you that the OPWDD providers, they worked with us and the CCOs. Because the CCOs, many of them were the providers. So it was a tremendous transformation, which I think is starting to find its way. Because as Michael was saying, now they're going back and saying, okay, what were the mistakes? And we're going to work together.

And I think that's what is so wonderful, is the collaboration. And if we can get this #3for5, we can continue that collaboration, which parents need to continue to be -- like myself, to continue to work and have quality of life and still maintain your individual at home longer because you're getting the good services from these provider agencies. So it's all a collaboration that needs to continue.

SENATOR SEWARD: Thank you for your assessment.

CHAIRWOMAN KRUEGER: Thank you very much, all three of you. Appreciate it --

MS. CONSTANTINO: Thank you.

CHAIRWOMAN KRUEGER: Our next panelists are Alcoholism and Substance Abuse Providers of New York State, John Coppola, and Coalition for Behavioral Health, Amy Dorin.

You can start in whichever direction you prefer.

MS. DORIN: We're going to start with John.

MR. COPPOLA: Good evening. I'm happy to be here.

And just want to begin by sort of echoing a point that a number of -- that, Senator Krueger, I heard you make, and Senator Harckham a little bit earlier, Assemblywoman Gunther, Assemblywoman Rosenthal, in terms of talking about the amount of resources that are committed to the crisis. And I think Senator Harckham's words were "drastically underfunded."

The magnitude of our response to the public health crisis that's been created by the addiction related to opioids and opioid overdose deaths -- the magnitude of our

response has not approximated the magnitude of the crisis. And that's a significant problem.

It is not acceptable that -- you know, there's a chart that I included in my testimony that shows the funding for local assistance programs in communities across the state beginning in 2013 and ending with the current year's proposal. And if you think about the work that you did last year, after the Senate and the Assembly were finished adding to what the Governor proposed, the result was a 1 percent increase over the previous year.

And that was in a year when we were talking about a record number of overdoses and a record impact of addiction on the system. And when we were all done with the budget, there was a 1 percent increase to help folks address this crisis. Which means, you know, all of the things you've heard people talk about relative to the cost of doing business were somehow, you know, also included.

And one of the things that I want to do -- I want to call a little bit of attention to the testimony that Ken Robinson gave a little bit earlier. And he talked about his experience working with AIDS and HIV. And his -- you know, he must have said three or four times "My heart is broken," and he was thinking about the lack of attention that we pay to people who are currently using, you know, drugs. And, you know, our lack of ability to see the fundamental dignity in those people. And so he was kind of surmising that it was a stigma which was the reason why we were so poorly funded.

And I want to call your attention to what happened specifically with AIDS/HIV. You all were responsible for a significant change in the response that that illness and that health challenge received, and that was that you increased the rates, the Medicaid rates for physicians who were supposed to be paying attention to that crisis. And as soon as the rates were increased, physicians started coming out of the woodwork to do that

work. Absolutely.

And I would suggest to you that if you take a page or two out of the playbook that you used in addressing the crisis that was caused by the incidence of HIV and AIDS, that that would go a long way toward helping us address the needs of people suffering with addiction to opioids and other drugs.

And I would just sort of suggest that the conversation be much broader than just the opioid crisis. It was alarming to read recently that the number of deaths attributable to alcohol doubled -- doubled -- in the last 10 years. And so when you think about, you know, addiction related to alcohol, addiction related to opioids, and we're starting to hear about methamphetamine and cocaine and fentanyl, it's a sizable public health issue.

And I believe that if you approach it the same way that you approached AIDS and HIV, look at the Medicaid rates and, you know -- and again, I think that is at the point when Assemblywoman Rosenthal asked the

question about why don't more doctors prescribe buprenorphine, why aren't more doctors getting involved.

There are a lot of doctors that are certified that are not prescribing to anybody, and they've made a decision that it's not good business for them to do so because the rates don't pay for the cost of doing the service, it's a bad idea. And so there's an inherent discouragement of offering the very service that people are talking about so frequently which is also, you know, medication-assisted treatment.

So it really is fundamentally a question of do we have the will to really address this problem and can we work looking at the Medicaid rates.

So our first priority this year is indeed the #3for5. And you've heard from everybody that if you don't have an economically viable, fiscally solvent -- fiscally sound organization, you are not in the best possible position to address the needs of people in need. And so we stand

firmly with our partner organizations in the #3for5 campaign.

The second one is really -- which I just identified, is to take a look at the Medicaid rates and to do something with Medicaid rates.

And the final point is to look at the possible revenue that you have at your disposal, whether it's the settlements from opioids, whether it's the tax on marijuana for adult users -- if that's something that you legalize -- if it's the Comrie-DenDekker alcohol tax which would literally tax maybe 5 cents for a drink, or if there's additional funds that go into the pharma fund. There are resources there if you want to do the job.

Thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

Amy?

MS. DORIN: Thank you. Good evening.

We really appreciate your convening of this joint legislative public hearing on the 2020-2021 Executive Budget.

I'm Amy Dorin. I'm the president and CEO for the Coalition of Behavioral Health. The coalition represents more than 100 community-based behavioral health providers who collectively serve over 600,000 New Yorkers every year.

I'm testifying today with my colleague John Coppola. The coalition and ASAP recently announced a strategic partnership to build a unified voice for behavioral health providers throughout the state, highlight integration as the future of our field, and improve care for individuals with mental health and substance use disorders. We're very excited about this partnership, and together the coalition and ASAP represent about 250 community-based agencies throughout New York State.

This is a critical time for behavioral health in New York. The opioid and suicide epidemics are taking the lives of thousands of New Yorkers every year. New York State has the opportunity at this moment to truly invest in behavioral health, tackle these

epidemics and emerging issues, and improve public health for the state.

Unfortunately, the current funding and support for the sector means that providers lack the flexibility to fully address these issues. Individuals throughout the state frequently encounter waitlists for services, which delays access to care and increases the likelihood of utilizing much costlier services such as the emergency room and inpatient hospitals. Clients also experience staff turnover that is detrimental to their care, as funding does not allow for sufficient salaries.

Our first and most important issue is the #3for5 campaign, which I'm sure you've heard all throughout the day. It is absolutely crucial. If we do not invest in our community providers, we're not going to go anywhere or be able to do anything. So we stand with human services coalitions from across New York State calling for the states to invest in a 3 percent increase on contracts and rates for the next five years.

Human services funding has been slashed by 26 percent since 2008, resulting in rates that are lower than 1980. The 800,000 New Yorkers who make up the human services workforce bear the brunt of this, with stagnant low wages which leave the average human services worker living at or below the poverty line.

One of our members today -- and it represents several members -- talked about their workforce that are homeless. They live in homeless shelters, come into work every day to help other people who are also on the brink of homelessness. I think that is quite a statement and very impactful.

This chronic underfunding threatens the stability of New York's entire human services sector. Thirty-nine percent of New York's human services organizations have less than three months of cash on hand. If you run an organization, that's very, very scary.

Organizations often have just a few late payments -- are a few late payments away

from being able to make payroll. Organizations struggle to pay for increasing requirements and demands necessary to conduct business, including widespread adoption of electronic health records, data analytics, cybersecurity -- all part of the cost of doing business.

For behavioral health, chronic underfunding has also led to the severe workforce crisis across the state. There's a 34 percent turnover rate, an increasing vacancy rate, with behavioral health providers reporting lower-level staff leaving for positions that pay better in retail and food service. And we do have staff leaving to work at Home Depot or McDonald's because the rate of pay is equal to what we're paying or more.

This is not easy work to begin with. While it can be immensely rewarding, hours are often inflexible and include nights and weekends, and common incentives like working from home are simply not available to many of the members of our workforce.

It is critical that programs are able to staff appropriately to serve individuals with mental health and substance use disorders, but low salaries make it impossible for providers to do so. There are less people coming into the field and less staying in the field -- and that is direct service as well as supervisors.

The second issue in our request or ask: Maintaining existing behavioral health funding. We were happy in the first round of cuts when the 1 percent did not affect agencies operating under the Mental Hygiene Law. We need to at least maintain what's happening now, and we must be represented on MRT II since our providers serve the highest-cost, highest-need individuals in the state.

Next ask: Ensuring that the opioid settlement funding responds to our epidemic. We will absolutely advocate for the settlement funds to be infused back into the system for substance use prevention and treatment, and we hope that you join us in

that.

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

CHAIRWOMAN WEINSTEIN: If you could wrap up.

MS. DORIN: I'll wrap up.

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

CHAIRWOMAN WEINSTEIN: That final --

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

de-designating. That means that they cannot do the business of serving children, and it's horrifying.

And the last ask has to do with integrating care to improve quality and access. And I'm looking at the model of the CCBHC, the Centers of Excellence for Behavioral Health -- there are 13 in the state, seven in New York City. And really an ask to replicate that model, which allows community providers to have the funding they need to do the services.

Thank you.

CHAIRWOMAN WEINSTEIN: Thank you.

There are no questions. Thank you for being here.

MR. COPPOLA: Thank you.

ASSEMBLYWOMAN GUNTHER: Well, I just --

CHAIRWOMAN WEINSTEIN: I'm sorry. Assemblywoman Gunther.

ASSEMBLYWOMAN GUNTHER: So I read -- I try to go along and read along -- you were quick, so it was hard. But, you know, when

I'm looking at this, we realize that not all of these requests will be fulfilled. So in my opinion, it's just like my kid's Christmas list -- you know, you've got to go for the ones that are most important to you.

MS. DORIN: Yeah.

ASSEMBLYWOMAN GUNTHER: And I think that's important. And I think it's important also, can we incorporate into like organizations that already are in communities?

I think a lot of the times when I go back to the HIV when that was going on, we used to ID physicians that were already existing in our community, you know, we did it kind of secretly behind -- you know, people would go in.

But what I'm saying is that there won't be enough money to support every agency that has come and testified today. So it's almost like we can't be redundant, because there's only a limited amount of money. So how can we get the best bang for the buck without redundancy?

I know that you're working together, but I almost think we have to do it just -- like it was different interagencies. They're doing lots to communicate together. They want DSPs to get a raise -- to get an increase, so they're working together on those things.

Well, as far as we look at the areas of New York State, the agencies that we can't have redundancy -- and the providers. And it's important. And -- because there's only that much money to go around. And you hate to keep saying no to people. So how can we make it more cost-effective with efficacy, is what I'm saying.

And, I mean, I think that brilliant minds, they do prevail, and there's got to be some way, because we're not going to get it all. And I know that. And I'm sure other people agree with me. I feel bad when people sit here and are asking for money and I feel like, you know, I'm going to be -- it's going to be disappointing.

So how could you not disappoint people

and utilize what you have and also collaborate together to provide the services that you really want for our communities?

MR. COPPOLA: I think there's two things specific to your point. One of them is to take advantage of the additional resources that we mentioned, to have the conversation about how can we utilize funds from the settlement funds to, you know, distribute in a way that will really make the kinds of changes we're talking about.

When we have the conversation about the marijuana tax, if that's something that happens, how do we make sure that we make the investment in prevention and treatment that we --

ASSEMBLYWOMAN GUNTHER: But we don't know that it's going to happen. So I'd rather look at what is in front of us, because that -- by the time the tax is, you know, when they start -- if they do get -- the tax comes, it's still going to be a length of time before that money will be able to be utilized --

MR. COPPOLA: Right.

ASSEMBLYWOMAN GUNTHER: -- for anything. So --

MR. COPPOLA: So what is in front of you, though, is the results of DSRIP No. 1. And DSRIP No. 1 -- if you say, okay, let's look only at the successful programs that drove savings. And those savings were largely driven by behavioral health organizations where there was a commitment of resources from DSRIP to those programs which drove savings.

So that is not only a question of making the investment, that's where the providers can say to you "We can help you close the gap." We can help you -- and I'll give you one concrete example which was incorporated into DSRIP.

There was a program in New York City that did case management with 750 folks who had frequent services paid for by Medicaid, and they were given case management and treatment for their addiction. And it saved those 750 individuals who received treatment,

saved in the same fiscal year $10 million. When the program increased from 750 to 1500, it saved $20 million.

So you have the ability to say, let's utilize what we know from DSRIP and let's project out how much savings will be generated if we make the investment in the community-based organizations that can drive it.

ASSEMBLYWOMAN GUNTHER: I agree with you. I agree.

CHAIRWOMAN WEINSTEIN: Thank you.

MS. DORIN: Thank you.

CHAIRWOMAN WEINSTEIN: Thank you for the work you do and for being here today with us.

MR. COPPOLA: Thank you.

MS. DORIN: Thank you.

CHAIRWOMAN WEINSTEIN: Next we have Northern Rivers Family of Services, William Gettman, to be followed by the Association for Community Living, to be followed by Families Together in New York State.

MR. GETTMAN: Good evening. My name is Bill Gettman, from Northern Rivers Family of Services. We're a mental health provider, a child welfare provider, and an educational provider in the Capital Region. We serve 18,000 children and adults in the 30-county area.

Thank you for your time today, and thank you for your public service.

I want to address three critical things related to the delivery of services for children and adults across New York State. First, as my colleagues have suggested, we need to invest in the #3for5 campaign. The #3for5 campaign is an overdue action by the Legislature and the administration to support the viability of our local not-for-profit sector.

Many people think of #3for5 as a shorthand for the workforce, but it goes beyond the workforce. It pays for things like physical security in our schools and in our residences. It pays for the IT costs that allow us to negotiate with managed-care

companies. It pays for heaters.

As I was sitting here today I received an email from my facilities director, who told me that one of the heaters in the residences had just blown up and we have an $18,000 expense tomorrow. In the past years I could go back to the state, I could go back to our funders -- OMH, OPWDD, OCFS and others -- and look for dispensation. That no longer exists. I have to go out and privately raise that money.

So we ask for #3for5. We need predictable funding over the next five years.

Related to that is the recommendation from Andrea Smyth and the Children's Mental Health Coalition for an appropriation to support the mental health workforce and a loan forgiveness program.

At Northern Rivers this year we piloted a loan forgiveness program for our staff. We privately raised $150,000 to go out and provide monthly stipends to our staff so they would stay and work for us, so they wouldn't be hired away to go to work for the

managed-care companies or for the state.

In that regard, I have one additional workforce story to share with you. We have a young man who is 18 years old. He lives in one of our group homes, and I'm proud to say he just got a part-time job. He is the assistant shift supervisor at a local coffee store here in the Capital District. He makes $16.85 an hour, and he works as many hours as he can schedule.

The staff person who takes him there every day and picks him up makes $13 an hour. And 25 percent of my staff have to work a second job to meet their needs.

So again, I encourage you to support the workforce in various ways through loan forgiveness as well as #3for5.

Last, I need to touch on the community-based services that are available under the CBFT services, the new Medicaid services. There are large waiting lists, there are turnover of staff, and they're not financial viable.

We are a large provider, and we

provide these services to several hundred families currently. We will lose $1 million this year based on the current rates. It's not a productivity issue, it's an insufficiency of the rate. If we can't meet this need to break even on this program, we will have to close it.

Which gets back to the question that Chair Gunther asked about how do we make sure we're having an impact, because these kids will end up in hospital rooms, in hospital EDs, they'll end up in homeless shelters, and their problems will escalate, therefore costing more Medicaid.

So again, I encourage you to support the human service sector through #3for5, the loan forgiveness, and look hard at the new state plan Medicaid services.

I appreciate your time and your service and your dedication. This is a tough budget. But I think we need to invest in kids, because kids are our future.

Thank you.

CHAIRWOMAN WEINSTEIN: Thank you for

being here today. Thank you.

Next, we have the Association for Community Living, Antonia Lasicki, executive director, to be followed by Families Together in New York State.

MS. LASICKI: Hi, good afternoon. Thank you so much for staying and listening for so long. Hi, how are you?

I'm going to be as brief as possible. I don't want to repeat a lot of what's already been said here. I do want to start out just by saying that we so support the $20 million that the Governor put in his proposed budget for OMH residential programs. These programs have been underfunded for many years -- some of them did not get increases for 20 years, literally. So it's very much appreciated, and we hope you will support that.

Just to put that into context, though, if you take -- we have about 40,000 units of housing operated by not-for-profit providers for people who are -- with serious and persistent mental illnesses who are

functionally impaired by those illnesses. So the people with very challenging behavior and medical issues, often on six to 12 medications each -- we have people with a high school diploma supervising all those medications, managing that care. Very complicated jobs, as other people have said.

And when you think about the $20 million over 40,000 units of housing, it comes out to about $500 per person per bed per year. So it's really -- because the housing system under the Office of Mental Health is so big, it's approximately a billion dollars of their budget. And so $20 million is a 2 percent increase. And when you've gotten nothing for years and years and years, 2 percent is not very much.

So we really need that money. It's going to offset other losses. So we -- but I must say, I do appreciate it. It's a very tough budget year. And I did want to just put a couple of things into context.

There was a couple of questions to the commissioner about the 2 percent workforce

increase, as compared to the statutory COLA that's been deferred 12 out of the last 14 years. So the statutory COLA was put in in 2006; we only got it two out of the 14 years since then.

So what's the difference? So the statutory COLA covers Office of Mental Health, OPWDD, OASAS, OCFS, OTDA, and Office for the Aging. So that's -- the extra COLA was for those six state agencies and all the providers who contracted with those six state agencies.

The 2 percent workforce COLA is only for OMH, OPWDD, and OASAS. So those other three state agencies have gotten nothing from the 2 percent workforce increases. They've got nothing for many years.

The other thing is, and I think Mike Seereiter spoke about this specifically -- or maybe it wasn't Michael, but -- the 2 percent workforce increase is only for the direct support professionals, as we know. But all those other workers in the organizations are not in that 2 percent.

So if you have a worker who is doing data entry for minimum wage -- and we have to enter every single gas receipt, every single expense, it's tedious work -- we have a lot of the workers like that, and they're not part of the 2 percent. So they're left out, even in the OMH, OASAS, and OPWDD systems.

So the 2 percent does not replace the COLA that we lost. The COLA that we lost is a completely different animal. And that's why everybody is asking for #3for5, because the #3for5 would take the place of the statutory COLA that we have lost.

The 3 percent for five years is a 3 percent COLA on the contracts, which is what the statutory COLA would have been -- not just for certain workers in certain categories. So the #3for5 is critical, because the longer we go with targeted workforce increases -- yes, we can give a 2 percent workforce increase to certain workers, but the agencies are still going to go out of business. They're still going to go out of business.

So it makes no -- it doesn't really make a lot of sense to just give a targeted workforce increase and let agencies sink. So we -- I often think about this, the targeted workforce increase idea, as kind of like a -- it's kind of a state idea where you're -- you know, you give CSEA workers a raise. You know, there's an arm of the state -- the CSEA workers, they get a raise, but nobody is concerned that the Office of Mental Health is not going to be able to continue to operate from an administrative/managerial point of view. They're still not going to be able to cover their rents, their utilities, their -- you know, liability insurance. All that gets taken care of.

But for us, it doesn't get taken care of. We get a targeted workforce increase to a direct care worker, and the rest is left alone, and we are -- a lot of our agencies, as you heard, you know, the cash on hand is two weeks.

It's really not -- it's not a healthy way to do business, particularly when you are

taking care of some of the most vulnerable people in the state, and you don't want providers to go out of business and have an emergency situation on your hands where you have to scramble and figure out how you're going to take care of people.

So the #3for5 really takes the place of the statutory COLA. The 2 percent targeted workforce increases are very much appreciated. It's a very tough year, we get that, and we appreciate it. But something else has to be done. We have to move forward in a different way. And I think the #3for5 campaign is a campaign that has got everybody on board under all six of those state agencies, all the advocates.

And so in terms of Assemblywoman Gunther's question, you know, where do you get the best bang for your buck, I think the #3for5 campaign is probably where you get the best bang for your buck. And -- but again, thank you all for your support, and we'll talk more over the coming months about all of this, I'm sure.

CHAIRWOMAN WEINSTEIN: Yes.

Assemblyman Santabarbara.

MS. LASICKI: Yes. Hi.

ASSEMBLYMAN SANTABARBARA: I just want to thank you for being here, and I also want to thank you for visiting my district.

MS. LASICKI: I'm sorry?

ASSEMBLYMAN SANTABARBARA: I want to thank you for visiting my district and for providing me the information back in Schenectady, Mohawk Opportunities, we had a meeting and it just kind of --

MS. LASICKI: I'm sorry. I'm having a hard time understanding you.

ASSEMBLYMAN SANTABARBARA: Oh, I'm sorry. I just wanted to thank you for being here and thank you for visiting my district over the summer.

MS. LASICKI: Oh, yes, yes, yes, yes.

ASSEMBLYMAN SANTABARBARA: Yeah, we got --

MS. LASICKI: I really liked that, yes.

ASSEMBLYMAN SANTABARBARA: And Mohawk

Opportunities -- and executive director Joe was there --

MS. LASICKI: Yes.

ASSEMBLYMAN SANTABARBARA: -- and provided me information ahead of the hearing.

MS. LASICKI: Yes. Yes.

ASSEMBLYMAN SANTABARBARA: That was very helpful, because there's a lot to take in at the hearing.

MS. LASICKI: Yes.

ASSEMBLYMAN SANTABARBARA: So I appreciate you taking the time. And, you know, the homes that we're talking about, the facilities, some of them are not far from where I live --

MS. LASICKI: Right.

ASSEMBLYMAN SANTABARBARA: They're certainly in my district. And we talked about the City of Amsterdam as well, a new project that's going to be --

MS. LASICKI: Yeah. Yeah.

ASSEMBLYMAN SANTABARBARA: -- coming online very soon. So I wanted to thank you for -- I know it's a short period of time,

but we did review that information and we will be fighting for you in the budget.

MS. LASICKI: Great. Great.

ASSEMBLYMAN SANTABARBARA: Thank you.

MS. LASICKI: Thank you.

CHAIRWOMAN WEINSTEIN: Thank you for being here today.

MS. LASICKI: Thank you.

CHAIRWOMAN WEINSTEIN: Next we have Families Together in New York State, Paige Pierce, to be followed by Jim Karpe.

And is Amber Decker here? No?

Yes, go ahead.

MS. PIERCE: Good afternoon. Thanks for sticking it out.

I'm Paige Pierce, I'm the CEO of Families Together in New York State. Families Together is a family-run organization that represents families of children with social, emotional, and behavioral health and cross-systems needs. We represent thousands of families from across the state whose children have been involved in many systems, including mental

health, addiction, special education, juvenile justice, and foster care.

I am one of those parents. I have a son who's 28 who's on the autism spectrum, and I've been advocating with him and for him over the last 25 years. Our board and staff are made up primarily of family members and youth who have been involved in these systems, and our 2020 policy agenda, which you have in my written testimony, is created by our families.

In 2011, when the Medicaid Redesign Team was launched, I was glad to serve as one of the people on the Children's Behavioral Health MRT Subcommittee. The central premise of redesign was that New York would rein in costs by investing in better, more creative preventive healthcare strategies.

Back then, we knew that the children's behavioral health system was underresourced. We knew that we had insufficient capacity to meet the needs of our children. The state acknowledged this reality. For children, unlike every other aspect of Medicaid, we

resolved that the state would spend funding most effectively by actually investing more.

But now, in 2020, despite several delays, the new services are finally here and we must acknowledge a new reality. After nine years, the promised expansion of 200,000 newly eligible young people who would be able to access a suite of innovative and evidence-based services known as the Children and Family Treatment and Support Services, CFTSS, has not been realized.

These services are designed specifically to be delivered in our homes, schools, and communities instead of waiting for families to reach crisis and rely on emergency rooms, residential placements, and police involvement. Today, only 6400 children are utilizing these services -- not because children no longer need them as they did back in 2011. In fact, depression and anxiety are rising among children and adolescents. Seventeen percent of high school students reported seriously considering a suicide attempt. Suicide is

the second leading cause of death among 15-to-19-year-olds.

And we heard earlier about, you know, all of the statistics: 54 percent of children with behavioral health needs don't receive the treatment that they need. Almost a decade since the MRT acknowledged the children's capacity crisis, the expansion of the children's service system has been delayed so long and supported so sparingly that the nonprofit community-based organizations and their workforce have been left in disarray.

Rates were set drastically lower than the actual cost of delivering these services. Even the enhanced rate during the first year wasn't sufficient to cover costs.

On December 31st of last year, despite the outcry from the children's behavioral health community, and with these services barely off the ground, the enhanced rates were rolled back as scheduled. As you heard from the commissioner earlier, that's the explanation for why they were rolled back, is

that it was -- that was the schedule.

Staff turnover is high, waitlists are common, and in some parts of the state, it can take half a school year to get into a therapy program that serves kids, and they have to travel hours for just an assessment.

The bottom line is that despite the fanfare and despite the years of preparation, we are not reaching nearly the number of children the state promised to serve. Cutting rates at this time has not only crippled providers, it has harmed children who will now not have the access to the services that they need.

Today, Medicaid is overspent by the standards set nearly 10 years ago. And before the original MRT plan has been realized, a new MRT II will now envision how they can further reduce costs locally. In my experience, I worry that children and families will be caught in the crossfire. They can't, again, be sent to the back of the line.

Will children have to wait yet another

decade for their needs to be a priority? I hope not. We must put children first. We must invest in services that strengthen families and help young people reach their potential.

Evidence is clear that exposure to childhood traumas, known as adverse childhood experiences, ACEs, can lead to poor health, mental health and socioeconomic outcomes later in life, health outcomes that are no doubt driving the increasing costs of Medicaid. Our failure to make investments in the mental health of young New Yorkers a decade ago can't be the reason we don't invest now.

What we do this year will impact entire generations of New Yorkers moving forward. That's why we're proud to help lead the Campaign for Healthy Minds, Healthy Kids in calling for a moratorium on all cuts to children's behavioral health services and to restore recent cuts to the CFTSS services. We also join the unprecedented coalition of human service organizations for the

#3for5 campaign that you've heard so much about today.

Our human service programs are the thing that will drive down the enormous cost of ER visits and unnecessary hospitalizations. You can see in my written testimony the other priorities that we have.

We just want to say how much we strongly support the Behavioral Health Priority Compliance Fund holding health plans accountable and enforcing mental health parity laws. We worked for years on the Timothy's Law campaign to ensure that parity was the law of the land, and we need to enforce it now.

If we fail to acknowledge the underresourced system and don't invest in our children today, we will most certainly continue to scratch our heads for decades to come, wondering how we can contain costs in human services and address the growing health and behavioral health needs in our state. Please be the progressive leaders that we need and that our children need.

CHAIRWOMAN WEINSTEIN: Thank you for being here. And as you said, we have your testimony, it's been circulated to members. So I --

MS. PIERCE: Thanks.

CHAIRWOMAN WEINSTEIN: No questions. Thank you.

Let me just ask again, is Amber Decker here? No. Okay.

So then Jim Karpe is going to be our last testifier.

MR. KARPE: Thank you.

CHAIRWOMAN WEINSTEIN: Thank you for being here.

MR. KARPE: Okay. Thank you to the members for sticking it out. It's been a marathon.

And here we are to talk about intellectual and developmental disabilities and I'll alert you right away, don't bother trying to follow along with the written testimony, because I'm going to vary widely from it. A lot's been said today, and I'm going to bounce off of some of that.

SWAN, for those who don't know, is an independent grassroots coalition of unpaid parents from across New York State. The only stake that we have in this system is the care of our children. I'm one of those unpaid volunteers, and I'm a parent of two young adults with developmental disabilities. So I often say I've got a caseload of two and also a caseload of 200,000.

I'm here today really to talk to you about accountability, about holding the system accountable and about holding ourselves accountable for asking the right questions, for looking into all the dark corners. We've done a pretty good job here today, but I'm going to make suggestions about some better work that we can do to continue to probe and continue to hold ourselves accountable and the system accountable.

And the first question I have is, why are we moving forward with managed care at all? The state now concedes that this will lead to no savings. So why do it? Perhaps

it leads to better quality, but I would read to you one quote from the top of page 4, "There is no definitive conclusion as to whether managed care improves or worsens access to or quality of care." And that's the conclusion of the congressional committee charged with reviewing managed care for Medicaid. So why move forward with it at all?

And if we can't save money through managed care, where can we save money? I've got some ideas. One place I can tell you where we can't save money is in comm-hab. Comm-hab right now, community habilitation, serves about 7,000 individuals in New York State at a total cost -- an average cost per person of 23,000. So even if we looked into each of those cases and found some savings, we wouldn't be able to save very much.

There is a place where we can save money. There's some big buckets of money, and specifically it's residential services. Residential services --

(Mic problems.)

MR. KARPE: Oh, I'm sorry. Is this better? Okay.

Residential services consume well over half of the OPWDD budget. And within that category, state services consume over $2 billion, at an average cost for state services' IRAs of $233,000 per person. So if we were to find 10 percent savings for those 7,000 people, we'd be able to have another 7,000 people in comm-hab. And even after finding that 10 percent savings in the state services, they would still cost twice as much as the nonprofit providers for the equivalent service.

And that leads me to another question. We have the MRT II busy looking at how to save money. And what makes us think that hospitals and unions will look to themselves for ways to save money? I think it's a tragedy if we allow that to move forward.

So I have a list of many other questions, but I'll close with this. What are you, the Legislature, doing to help give OPWDD the flexibility and the power that it

needs to actually make change in the system?

OPWDD's hands are tied. They don't actually control the licenses of the CCOs, they are -- we've heard today about having to put stuff up to DOH. We've heard about the collective bargaining agreement. What can we do to actually free up OPWDD to change the system?

That's the end of my time. I invite you to ask me some of the questions you've asked others, such as how are the CCOs doing.

CHAIRWOMAN WEINSTEIN: Senator Jackson.

SENATOR JACKSON: Good afternoon.

First let me thank you for coming in. And I came in later, so I didn't hear all of the testimony. But you asked a question about what can we do. So I'm sure that you have suggestions for the MRT --

MR. KARPE: The MRT II.

SENATOR JACKSON: -- II. So are some of those incorporated in here? Or you're going to be submitting those to the design team?

MR. KARPE: We can submit them to the design team.

It was breaking news about it, and we -- but I would echo Michael Seereiter in saying that it's vitally important that there be representation of all parties.

SENATOR JACKSON: On the redesign team, is that correct?

MR. KARPE: On the redesign team. And that there be an opportunity to review the results, and that there be actual stakeholder engagement.

SENATOR JACKSON: Now, in my understanding -- and you probably know more that I do, because you're following this very closely because of your advocacy on behalf of not only your two adults but, you said, 2,000 other people involved.

So if we do not agree with the redesign team and do not adopt their recommendations, then we have to deal with a $2.5 billion deficit. One way or the other, do you see the redesign team and them coming forward, whatever they're going to come

forward with -- do you think it's going to be positive overall for all of the constituents, your children and others, with regards to children with mental health or developmental disability issues?

MR. KARPE: I unfortunately don't have much faith. It's being led by the head of a hospital system and the head of a union.

SENATOR JACKSON: And that's why you say it's imperative -- and these are my words -- imperative that you have activists and parents that have been involved from a leadership point of view, like yourself and others that have testified, as part of the redesign team.

MR. KARPE: I would concur with your use of the word "imperative." Thank you.

SENATOR JACKSON: Well, let me -- I wanted to thank you and everyone else that came in in order to give testimony, because it's extremely important overall.

And the leaders here have been here for days hearing testimony; I'm just spotting here and there, being in other hearings. So

thank you for coming in and giving testimony.

Thank you, Madam Chair.

CHAIRWOMAN WEINSTEIN: Thank you.

Assemblyman Ra.

ASSEMBLYMAN RA: So thank you for your patience in waiting to testify today.

So you closed with a potential question to ask you, so how are the CCOs doing?

MR. KARPE: So Assemblywoman Missy {Miller} said that she was on her third -- I'm on my eighth care manager in 19 months. Before then, I had the same MSC for five years. So just on that metric, I'd say it gets an F.

I have -- I have hope for the future that with a lot of hard work, a lot of actually developing the IET {ph} systems that are necessary to gather information, that it's possible to salvage this. But right now, it's -- from my viewpoint as a parent, from the viewpoint of the parents that I speak with, it's just not the rosy picture that you've been presented with today.

ASSEMBLYMAN RA: What have you seen in terms of, you know, the reasons why you've had so many? You know, are they just -- you start working with one and then they leave and go somewhere else, or --

MR. KARPE: They leave because the work is very frustrating, because there's so much emphasis on metrics versus helping people. People get into this profession because they want to help others, and a large increase in salary doesn't make up for not feeling a sense of purpose.

So people are motivated by money, purpose, mastery. You can give people a lot of money -- if they don't feel a sense of purpose, if they don't have a chance to master their tasks, they're going to leave. That's my belief and my experience.

ASSEMBLYMAN RA: Thank you.

CHAIRWOMAN WEINSTEIN: So thank you for being here and waiting through the end of the hearing to testify.

So this concludes the Mental Health Joint Budget Hearing. Committees will

reconvene tomorrow morning at 9:30, where we will have joint fiscal committee hearings on the Higher Ed portion of the Executive's budget.

Thank you all.

(Whereupon, the budget hearing concluded at 5:45 p.m.)