CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON HEALTH JOINTLY WITH THE
COMMITTEE ON HOSPITALS

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October 31, 2019
Start: 10:14 A.M.
Recess: 1:31 P.M.

HELD AT: Council Chambers – City Hall

B E F O R E: MARK LEVINE
Chairperson

CARLINA RIVERA
Chairperson

COREY JOHNSON
Speaker

COUNCIL MEMBERS: Diana Ayala
Mathieu Eugene
Alan N. Maisel
Francisco P. Moya
Antonio Reynoso

A P P E A R A N C E S (CONTINUED)

Dr. Mitchell Katz, NYC Health & Hospitals

Dr. Theodore Long, Chief Medical Officer
NYC Health & Hospitals, Gouveneur

Marielle Kress, Executive Director, NYC Care

Helen Schaub, Policy & Legislative Director for 1199

Valerie Goss, H&H Employee and Delegate for 1199

Lori Ann Zay. Employee at Community Health Center of Richmond, Staten Island

Judith Cutchin, Nurse at Woodhull Hospital, Brooklyn, Board of the Directors, New York State Nurse Association, NYSNA & Executive Council President representing Public Health System of Nurses

Sonya Lawrence, Nurse, Lincoln Hospital, Bronx

Rose Duhan, CEO, Community Healthcare Association of New York State, CHCANYS

Dr. Juan Tapia, Physician, Somos Network

Max Hadler, Director of Health Policy, New York Immigration Coalition

Arlene Cruz, Health Programs Manager, Make the Road New York

Maryam Mohammed, Government Relations Associate, planned Parenthood of New York City

Pinzon, Director of Care Services, Community Service Society

Natalie Enterano, Care for the Homeless

Holly Natiaga, AVP of Group Network and Executive Initiatives , Urban Health Plan Appearing for P Paloma Izquierdo-Hernandez, Urban Health Plan

Carlyn Cowen, Chief Policy and Public Affairs Officer, Chinese-American Planning Council, CPC

Michael Pereiera, Health Outreach Coordinator, Hispanic Federation

Hope Glassberg, SVP of Government Affairs and Strategies, Hudson River Health Care

Mary Ford, Director of Evaluation and Analytic, Primary Care Development Corporation, PCDC

Patrick Kwan, Senior Director for Advocacy and Communications, Primary Care Development, PCDC

Sean Leahy, Hudson River Healthcare

Andrea Bowen, Principal, Bowen Public Affairs Consulting, Ccoordinator of the Transgender, Gender Non-Conforming and Non-Binary or TGNCNB Solutions Coalition

Leon Bell, New York State Nurses Association

Anthony Feliciano, Director, Commission on Public Health System

Domna Entenades (Senior Staff Attorney, Legal Health Division, New York Legal Assistance Group, NYLAG

Sasfir Efman Policy Coordinator, Coalition for Asian American Children and Families

2 [sound check] [pause] [gavel]

3 SERGEANT-AT-ARMS: Quiet, please.

4 SPEAKER JOHNSON: Good morning. I'm Corey
5 Johnson Speaker of the New York City Council, and I
6 want to thank you all for being here today. I want
7 to start by thanking Council Members Mark Levine and
8 Carlina Rivera for holding this important hearing.
9 Health care is an existential issue. It is a life or
10 death issue. It is a make or break financial issue,
11 and it is a peace of mind issue. It is easier than
12 ever to access healthcare from the Affordable Care
13 Act, NYC Care,. We have made a lot of meaningful
14 progress in getting more people enrolled in health
15 insurance, but it's not good enough, and while we
16 probably need federal intervention to truly solve our
17 healthcare problems, as a city we could be doing a
18 much better job. Every New Yorker deserves access to
19 healthcare that they will actually use. Too many
20 people have been left behind without coverage or that
21 access to culturally and linguistically competent
22 healthcare without access to care in their
23 neighborhoods, and for me, this is a deeply personal
24 issue. I lost my job shortly after I was diagnosed
25 HIV Positive when I was 22 years old in 2004, which

2 meant that when I lost my job I lost my health
3 insurance right after getting an HIV diagnosis. It
4 is one of the toughest things that I've ever gone
5 through, but the first place that I went to after I
6 seral converted and lost my health insurance was
7 aperture, which is one of the top LGBTQ affirming
8 minority focused Community Health Centers in New York
9 City, and it was the staff there that got me enrolled
10 in ADAP, the AIDS Drugs Assistance Program. Aids
11 Drugs Assistance Program, and connected me to care
12 that was right for me. I know the difference that
13 great healthcare can make, and that is why I am
14 proudly sponsoring Introduction 1668 with Council
15 Members Levine and Rivera. It will create a health
16 access program that goes beyond the H&H system, and
17 connects anyone who participates in a coordinated
18 personalized care in their communities. NYC Care
19 relies just on H&H facilities. So, it can't reach
20 all of New York City's most vulnerable districts. For
21 example Queens Community District 7, which is
22 Flushing, Murray Hill and Whitestone have the highest
23 uninsured rate in the entire city at 5.5%, and it
24 doesn't have a single public hospital facility.
25 Brooklyn Community District 7, which is Sunset Park

2 and Windsor Terrace has an uninsured rate of 12.4%
3 and no public hospital facilities nearby. Staten
4 Island doesn't have an H&H acute care facility
5 providing specialty services. How can we say we are
6 adequately serving all New Yorkers when some need to
7 travel far from home to access care? But there is a
8 simple solution here. The city is filled with local
9 providers offering excellent care. They're called
10 Federally Qualified Health Centers, FQHCs. You will
11 hear a lot about them today. New York's 500 FQHC
12 sites serve 1.3 million patients including 370,000 in
13 a language other than English. The access program
14 created by Introduction 168 will include not just the
15 H&H system, but FQHCs. This would help not just those
16 who are uninsured, but every New Yorker looking for
17 help in navigating the healthcare system. To
18 achieve—to achieve true access we have to connect New
19 Yorkers to healthcare sites across the city where
20 they live. You need to be able to go to a hospital in
21 your borough or get primary care in your
22 neighborhood. If you struggle with coverage, you
23 should not have to go to an H&H facility that's
24 nowhere near your home just to get care on a sliding
25 scale, and we shouldn't be drawing patients away from

2 local providers that speak their language and offer
3 diverse tailored services, and because so many New
4 Yorkers without—with insurance need a little help in
5 figuring out how to use it, participants will also
6 have access to telemedicine services, and to Patient
7 Navigator to help them coordinate primary care and
8 specialty care, access medication, and hopefully
9 minimize costs. If you're a 25-year-old freelancer
10 with insurance you bought on the exchange, it could
11 be daunting to figure out what kind of coverage you
12 have, how to find specialists, how to make sure your
13 medical records are shared, and how to get
14 prescriptions at the lowest cost. This take the
15 guesswork and confusion out of that process. You have
16 someone that will help you through all of that at no
17 extra cost. We have all the tools we need to make
18 New York a healthier, fairer city. I hope this
19 hearing is the beginning of that conversation on how
20 we can work together, and before I turn it over to
21 Chair Levine, I just want to say I'm happy to have
22 the team come up that's going to testify on this from
23 the Administration H&H. I just want to start off
24 this hearing, and I think Chair Rivera and Chair
25 Levine would agree with me on this. We are so lucky

2 to have Dr. Mitchell Katz leading H&H in New York.
3 He is—has done an incredible job in a short amount of
4 time and taking a really precarious financial
5 situation that the system was in, and turning it
6 around without compromising quality services, and
7 patient care in the system. We have the greatest
8 public hospital system in the world. When the
9 President of the United States is in New York, if
10 something bad happens, they are slated to go to
11 Bellevue, which shows how great our system is, and
12 Dr. Katz, I think you've just done an amazing job
13 under really difficult federal conditions in
14 stabilizing the system and continuing to bring in
15 revenue and getting care out there to communities
16 that need it. And so we are really grateful for your
17 leadership, for your service, but we think we need to
18 go deeper. We think we need to go even farther than
19 H&H, and that is what this hearing is going to be
20 about today, and sow with that, I turn it over to
21 Chair Levine.
22 CHAIRPERSON LEVINE: Thank you so much.
23 [applause] Thank—thank you so much, Mr. Speaker. I'm
24 trying to resist unkind thoughts about the President
25 falling sick in New York City. I'm not going to go

there. Good morning everyone. I'm Mark Levine, Chair of the City Council's Health Committee. I am pleased that we are joined today by fellow Council Members Diana Ayala, Dr. Mathieu Eugene, and Council Member Bob Holden. I, too, am thrilled today that we'll be hearing from the leadership team of Health and Hospitals, and Dr. Katz, I consider you the best public hospital leader in America. We're so grateful for your leadership here. I'm also thrilled that we're joined today by leaders of the workers who make our healthcare system work including NYSNA and 1199. [cheers/applause] Thank you. We—we are here today to discuss universal health access in New York City, true universal access available to all regardless of where they live, regardless of what neighborhood they are in, regardless of their ability to pay, and yes regardless of their immigration status. Sadly, we have not yet fulfilled that promise for hundreds of thousands of our fellow New Yorkers, people who often because they are undocumented don't qualify for public health insurance, and get no medical care until they are in crisis, and land in the emergency room, a situation, which is bad for patients, which puts the broader public health of our city at risk,

2 and which imposes an extraordinary financial burden
3 on our public hospitals. This is unacceptable. We
4 need a system that give primary access to everyone
5 with services in the neighborhoods where they live,
6 in the languages that they speak, on a sliding fee
7 scale that they can afford, and the only way we can
8 achieve this citywide comprehensively at the scale we
9 need is by building on our phenomenal network of 500
10 community-based health centers also known as FQHCs.
11 These are the health providers that are on the ground
12 in communities building trust in relationships and
13 cultural sensitivity, and it would be crazy to cut
14 them out of a program that has as one of its primary
15 goals allowing undocumented immigrants to feel
16 comfortable accessing primary healthcare. Now, our
17 public hospitals are a true treasure, but they simply
18 can't do this alone, and that's why today we're
19 conducting this hearing on an important piece of
20 legislation, Intro 1668 to ensure that participants
21 in the city's NYC Care Program have the chance to
22 access primary care not just at H&H facilities but at
23 community-based health centers in every neighborhood
24 in this city with primary care physicians, and
25 practitioners to help direct, develop and coordinate

2 their treatment, testing and other services with the
3 comprehensive program of Patient Navigators, with
4 Telemedicine Service available 247, with seamless
5 integration to specialists in the H&H system. This
6 is how we will truly achieve healthcare for all in
7 the city. Lastly, I want to mention that if you care
8 about health policy in this town and if you're here
9 today I know you do, then you should be incredibly
10 thankful that you have the most phenomenal team
11 staffing the City Council's Health Committee in Sara
12 Liss, Ze-Emanuel Hailu, Emily Barcan (sp?) Laura Hunt
13 and Lewis Cholden-Brown. Can you all give us the big
14 [applause] and also, I want to acknowledge the
15 incredible work that my committee, my staff members
16 have done, Aya Keefe, Amy Slattery, and Winthrop
17 Roosevelt, and with that, I'm going to pass it back
18 to my partner in all things health, and Co-Chair of
19 this hearing Carlina Rivera
20 CHAIRPERSON RIVERA: Thank you.
21 [applause] Hi everyone. Good morning, good morning.
22 It's great. It's awesome. So, good morning every
23 one. I am Council Member Carlina Rivera, Chair of
24 the Hospitals Committee, and I also want to recognize
25 members of my committee Council Members Eugene and

2 Ayala. Health and Hospitals remains the largest
3 provider of healthcare to New Yorkers who are
4 uninsured and they remain committed to providing care
5 to all individuals regardless of their ability to
6 pay. Earlier this year H&H launched the NYC Care
7 Program, a healthcare access program that guarantees
8 low cost and no cost services to New Yorkers who do
9 not qualify for or cannot afford health insurance
10 provided through H&H. In addition to all of the
11 services H&H has always provided to the uninsured
12 community, those how are enrolled in NYC Care receive
13 a membership card, can choose a primary care provider
14 and are given access to customer service
15 representatives for assistance accessing care,
16 accessing care. Those who are uninsured yet eligible
17 for health insurance will receive assistance
18 enrolling in insurance in an effort to lower the
19 number of visits to H&H by uninsured yet insurable
20 patients. NYC Care promotes the use of primary and
21 preventative care, which will help enrollees avoid
22 unnecessary emergency room visits, and promote better
23 health outcomes and access. Currently, NYC Care is
24 operating in the South Bronx with plans to expand to
25 Brooklyn and Staten Island, and by 2021, the program

2 plans to be located in all five boroughs. I am proud
3 that our city is focusing on supporting our immigrant
4 communities, a necessary endeavor while the Federal
5 Administration continues their relentless and
6 zenophobic attacks on some of our city's most
7 vulnerable. There are an estimate 560,000
8 undocumented individuals in the city, and only 42%,
9 about 235,000 are in insured, leaving 324,800 without
10 health insurance. This number is expected to rise
11 into the United States Department of Homeland
12 Security's DHS intention to alter the definition of
13 public charge, which would discourage immigrants and
14 their families from accepting public benefits
15 including public health insurance. We clearly need
16 to ensure that all of our health programs gear
17 towards uninsured individuals including those who are
18 undocumented are operating well providing meaningful
19 care and are efficient. I am hoping to learn more
20 about the roll out of NYC Care in the Bronx today.
21 Specifically, I want to know that we have reached as
22 many people as possible. We must examine outreach
23 efforts, who the remaining uninsured are, and what
24 more we can do as a city. I want to hear today how
25 the program is adding—is aiding those in the South

2 Bronx, and about the services participants in NYC
3 Care are taking advantage of. As fellow co-sponsor
4 of Intro No. 1668, I believe that we need a more
5 robust program in place, one that reaches every
6 community district, and includes more providers. We
7 should also make sure that the programs currently in
8 place as effective as possible. I'm also a proud
9 sponsor of Reso No. 918 calling on the State of New
10 York to pass and the Governor to sign S3900/A.5974,
11 an act to amend the Services Law in relation to
12 coverage for healthcare services under the Basic
13 Health Program for individuals whose immigration
14 status renders him or her ineligible for federal
15 financial participation. [Cheers/applause] Okay.
16 The Affordable Care Act directs the Secretary of
17 Health and Human Services to establish a basic health
18 program that provides an option for states to offer
19 particular health coverage. New York State's basic
20 health program is known as the Essential Plan. The
21 bills in Albany sponsored by State Senator Rivera,
22 and Assembly Member Gottfried will would provide
23 adult immigrants with access to health insurance
24 coverage that is equivalent to the coverage offered
25 to their citizen or lawfully present council parts by

2 providing healthcare to all individuals regardless of
3 immigration status. The bill would improve public
4 health and access to healthcare as previously
5 discussed. I will now read a statement by its prime
6 sponsor Council Member Council Member Adams about
7 this resolution. Council Member Adams could not
8 join us today, but I want to make sure that we get
9 her statement on the record as we are in full support
10 of making sure that we pass this law, and we support
11 every single New Yorker to receive quality
12 healthcare. So thank you for this important hearing
13 today on universal—on universal healthcare access.
14 Although the state and city of New York are ahead of
15 many other states in providing healthcare access, we
16 have not done enough to ensure our undocumented
17 immigrant population is insured. I represent District
18 28 in Southeastern Queens, a neighborhood with a
19 large immigrant population many of whom are
20 uninsured. Because of this, I've introduced
21 Resolution 918, which calls on the State of New York
22 to pass bills sponsored by Senator Gustavo Rivera and
23 Assembly Member Richard Gottfried to expand
24 healthcare coverage services under the Essential Plan
25 Programs to all qualifying New Yorkers regardless of

2 their immigration status. Currently, New York
3 State’s Essential Plan Program receives a large
4 portion of its funding from the federal government.
5 Because of this, our undocumented population is
6 completely left out of the program and far too often
7 left out in the cold without any insurance at all.
8 The state bill, which my resolution supports would
9 solve this issue by building upon the current
10 essential plan structure, and create a state funded
11 essential plan for all New Yorkers. According to the
12 Mayor's Office of Immigration Affairs there are an
13 estimated 560,000 undocumented individuals in New
14 York City and over half of them are living without
15 any health insurance. The lack of coverage has a
16 high—a higher impact on undocumented since
17 undocumented women of low and moderate income are
18 excluded from the Essential Plan they face major
19 financial barriers in situations where reproductive
20 health services are needed. The need for healthcare
21 should not be dependent on a woman’s immigration
22 status. With so many states restricting vital health
23 an reproductive services, our city should be
24 expanding access, not restricting it. We need to do
25 better by the undocumented population in our city.

2 Furthermore, we need to do better by all women in our
3 city. Undocumented women are among our most
4 vulnerable population. Resolution 918 will make life
5 a little bit easier for them. Thank you.
6 CHAIRPERSON LEVINE: Thank you so much
7 Chair Rivera. I want to acknowledge we have been
8 joined by fellow Health Committee member Andy Cohen,
9 and I want to call our first panel led by Dr.
10 Mitchell Katz, and other executives at H&H including
11 Marielle Kress, Ted Long, DR. THEDORELONG:, and Risi
12 Sude (sp?) [background comments] And I would like to
13 ask our Committee Counsel, Sara Liss, when—when our
14 panel is ready to administer the affirmation.
15 COUNSEL SARA LISS: Anyone who plans to
16 testify or answer questions, please raise your right
17 hand. Do you affirm to tell the truth, the whole
18 truth and nothing but the truth in your testimony
19 before this Committee ,and to respond honestly to
20 Council Member questions?
21 PANEL MEMBERS: [off mic/in unison] I
22 do.
23 COUNSEL SARA LISS: Thank you.
24 DR. MITCHELL KATZ: Good morning,
25 Chairperson Levine--

2 SPEAKER JOHNSON: [interposing] Mitch,
3 turn your mic on.
4 DR. MITCHELL KATZ: Thank you.
5 Chairperson Levine, Chairperson Rivera and committee
6 members, it's—it's just about two years since I
7 returned home, and it's been so great largely because
8 with all the horrible rhetoric of the federal
9 government, it's so nice to be in a place where the
10 government is actually responsive, thoughtful,
11 inclusive in trying to do the right thing and I
12 can't—I can't imagine a better time to be in New
13 York. So, thank you for all that you do for us the
14 Health and Hospital system and for the entire city. I
15 appreciate this opportunity to update you on the
16 implementation of NYC Care. I have practiced
17 medicine for 30 years in public systems across the
18 country, and those systems are fragile. Washington,
19 D.C. used to have a public hospital. No more. Boston
20 used to have a public hospital. No more.
21 Philadelphia used to have a public hospital. No
22 more. Milwaukee used to have a public hospital. No
23 more because they didn't have City Councils like you
24 and Mayors like Bill de Blasio, and people who really
25 cared about making sure that there was access through

2 a public system. We currently take care of over a
3 million patients each year. Ultimately, though, and
4 I think Chairperson Rivera spoke to it very well, we
5 need a system a single payer system that guarantees
6 care to everyone, and guarantees that the money goes
7 to the care of the people, that the money doesn't go
8 to insurance programs that spend money on
9 administration and denying people care and reviewing
10 the care that the primary care doctor has already
11 approved, and so I hope that some day soon we're
12 going to see in New York and maybe someday even in
13 our country a single payer system. I was proud in
14 January to join the Mayor in announcing the launch of
15 the largest most comprehensive initiative in the
16 nation to guarantee healthcare to every New Yorker.
17 No one should live in fear. I particularly resonate
18 with the Speaker's story about what it would—what it
19 must have been like, how brave he was, you know, at
20 such a young age to find himself without any
21 insurance, and have to circumvent our system. That
22 happens all the time in New York still with people
23 who are new to our country. We run a phenomenal
24 system in Health and Hospitals, but how would you
25 know if you just came to our country? How would you

2 know where to go, who would tell you? How could you
3 find your way? So there is so much more that we can
4 do together. Through New York City's guaranteed
5 commitment, we are increasing enrollment in the
6 city's public option Metro Plus for insurance
7 coverage on the health Exchange, and enrolling those
8 who do not qualify for or cannot afford health
9 insurance to New York City Care, which will be
10 available across the five boroughs by the end of
11 2020. It builds on the initiatives that I previously
12 worked on, Healthy San Francisco, and My Health in
13 L.A. While I'm very proud of those programs, I have
14 to say that New York City Care is a much broader set
15 of services, and in that sense, really I think
16 exceeds the other programs, and certainly when it's
17 fully implemented it will exceed it as well in
18 numbers. We had a very successful Bronx Launch. I'm
19 very proud that our hospital and clinic
20 representatives are here because they did phenomenal
21 work. We are on track to hit for the Bronx 10,000
22 patients in the first six months, and we have
23 actually now hit where it's 7,500 people have been
24 enrolled in the first three months. So, we're
25 officially updating our count. We were at 5,000 at

2 two month, 7,500 at three months. We have enrolled
3 people from every Zip Code in the Bronx, and we have
4 also kept our commitment that we would see every
5 patient who enrolls would get an appointment with a
6 primary care provider within two weeks, which is a
7 standard that the community doesn't need fro
8 privately insured patient for any of you who have
9 tried to get an appointment with your—with a primary
10 care doctor, but we realize that our patients have
11 special challenges and so when they need care, we
12 want to be able to deliver that. We have provided
13 3,000 prescriptions after hours in the program. So
14 Health and Hospitals always provided free and low-
15 cost prescriptions, but that sometimes meant if
16 someone went to an emergency room on Friday, they had
17 to wait until Monday to get the prescription. I find
18 that unacceptable, and—and bad business as well as
19 bad medicine, right. If someone comes on a Friday
20 and they have shortness of breath due to asthma and
21 they can't get their inhaler 'til Monday, they're
22 going to be back in the emergency room on Saturday.
23 So, the fact that we've been able to do those after
24 hour prescriptions I think means a lot. We do within
25 NYC Care comprehensive primary care and specialty

2 care services at all our hospitals including our
3 Gotham federally qualified health center. It’s all
4 based on sliding scale fee based on income, household
5 size. There are no membership fees. There are monthly
6 fees, and besides the affordable prescriptions and
7 extended hours, we have hotline that connects people
8 to the care and again, this is like a real, real
9 people. This is not like leave a message and pay
10 that somebody will call you back. This is real
11 people in a call center with multi-lingual
12 capabilities. I want to thank our work with the
13 Mayor's Office of Immigrant Affairs and the Mayor’s
14 Fund to Advance New York. We have contracted with
15 five community-based organizations. We have provided
16 grants of a total of $650,000 to Emerald Island Isle
17 Immigration Center, Bronx Works, Northwest Bronx
18 Community and Clergy Coalition, Macon New York City.
19 ACOM (sic) New York City, and Sauti Yetu Center for
20 African Women to hire 15 full-time staff members who
21 refer uninsured New Yorkers in the Bronx for
22 insurance screening and enrollment in NYC Care in a
23 culturally appropriate and sensitive manner. We’ve
24 launched a multi-lingual and multi-platform public
25 awareness campaign to promote New York City Care

2 launch in the Bronx. We were able to get pro bono
3 support for the development of the posters, and I
4 hope you've seen them and like how well it captures
5 visually the ethnic diversity of New York, and we
6 also have paid advertisement for placing those ads.
7 As the program rolls out we intend to replicate this
8 and to work with community groups and ethnic media to
9 reach every community in every borough. We have been
10 working closely with non-Health and Hospitals FQHCs.
11 I love federally qualified health centers. I entirely
12 agree with the Speaker that they provide incredible
13 care in New York City and across this country and
14 feel a very valuable gap. One of our—the issues with
15 federally qualified health center is that they need
16 great specialty care connections because under the
17 legislation that governs Federally Qualified Health
18 Centers, it's primary care. I'm a primary care
19 doctor. I love primary care, but sometimes the woman
20 has a lump in the breast, and she needs specialty
21 care. She needs a biopsy under CT guidance. Someone
22 has developed bleeding. They need to be seen by a
23 gastroenterologist. These plans of services that are
24 not part of the spectrum of federally qualified
25 health centers. So, we've been working very closely

2 with our partners to be sure that when their patients
3 need specialty care we're providing it quickly for
4 their patients. We're providing it with information
5 back to them. We refer them back to their original
6 sites so that clinics do not lose patients and
7 patients do not lose their clinics. We've also been
8 working hard with the Federally Qualified Health
9 Centers to be sure that they scripts of the call
10 centers help patients to recognize that if their
11 current care is at a Federally Qualified Health
12 Center, that's great. We fully support that, and
13 they can join NYC Care in order to get their
14 specialty care, but that we reinforce their staying
15 with their federally qualified health center. So, in
16 conclusion, I've been very excited about the
17 progress. I think 7,500 people in three months in
18 every borough with a visit within every—with two
19 weeks, 3,000 prescriptions after hours . To me
20 that's a good three months of work, but there's a lot
21 more to do, but that's just the beginning, and I look
22 forward to working with all of you on this bill on a
23 vision that includes guaranteed healthcare for every
24 New Yorker. Thank you and I'm here as well as
25 Marielle Kress who's the Executive Director or to

2 answer any questions that we can along with our
3 colleagues from Public Health and DR. THEDORELONG: ,
4 our head of Primary Care.
5 SPEAKER JOHNSON: Thank you, Dr. Katz. I
6 want to start again by thanking you for being here.
7 As we said before, e feel really lucky that our city
8 has you, and since I was Health Committee Chair in
9 the last session of the Council I was following your
10 previous work in San Francisco and Los Angeles. What
11 you have done for municipal healthcare is remarkable,
12 and I look forward to continuing to work together to
13 deepen that and strengthen that, and because of that
14 fantastic experience, I want to start by asking you
15 what you think makes the healthcare system
16 successful. So, I want to ask what are the driving
17 forces that make people actually access care? Is it
18 cost? Is it convenience? Is it their relationship
19 with their providers? Is it cultural competence? Is
20 it whether their provider speaks their language?
21 What are the driving factors that people use to
22 access care?
23 DR. MITCHELL KATZ: I think the strongest
24 is certainly relationship with their provider, and
25 relationship encompasses all of the other things that

2 you mentioned. There's a very strong body of work
3 that when people are seen by doctors and nurses who
4 look like them, they're more satisfied with their
5 care, and they feel more connected. That being said,
6 good providers especially in a city like New York
7 City learn how to work well with the diverse
8 population, but you—it's always better for people to
9 get services where other people speak their language,
10 other people are from their backgrounds, other people
11 understand their live experience.
12 SPEAKER JOHNSON: You know, Health and
13 Hospitals' success as a safety net provider is
14 unparalleled. It's actually I think impossible to
15 measure how much it's meant to New York City since
16 its creation, but its physical reach is limited
17 because of you don't have a facility everywhere.
18 It's impossible to. There are only so many
19 facilities that you currently control. Do you think
20 that people are more likely to access care if it is
21 close by to where they live in their community?
22 DR. MITCHELL KATZ: Yes. I think that
23 that is very strong. I think, you know, the only
24 caveat I'd put is that that—that's for primary care
25 SPEAKER JOHNSON: For primary care.

2 DR. MITCHELL KATZ: Which is to say
3 because you—it becomes impossible to provide high
4 quality specialty care in small areas because usually
5 specialty care requires diagnostic equipment, and
6 other things that just can't be replicated. So, even
7 our eleven hospitals we're working toward a vision
8 where every hospital is meeting its community need,
9 but every hospital doesn't do everything just because
10 we can't get the—the critical mass of enough doctors,
11 enough equipment in every place, but primary care
12 should be as close to where people live and work as
13 possible.
14 SPEAKER JOHNSON: But for specialty care,
15 if you were someone who lived in Brownsville, it
16 would be better to actually have the specialty care
17 at least be in your borough--
18 DR. MITCHELL KATZ: Correct.
19 SPEAKER JOHNSON: --rather thang going
20 to--
21 DR. MITCHELL KATZ: Absolutely.
22 SPEAKER JOHNSON: --Manhattan for that
23 specialty care.
24 DR. MITCHELL KATZ: Yes, yes, absolutely.
25

2 SPEAKER JOHNSON: And with the
3 transformative work that you've been doing at H&H, I
4 want to ask you about what you think people's
5 perceptions and historic issues with H&H. Would it
6 make some less likely to seek care there? Would
7 people be less likely to seek care at H&H?
8 DR. MITCHELL KATZ: I think there are—
9 there is some problematic history of H&H. I think
10 the quality of the medical, nursing, pharmacy, social
11 work there was always Great. I think what wasn't
12 great is customer service, and so, I think that some
13 people may have had the experience of calling and no
14 one answered or calling and being told that there
15 wasn't an appointment for months and moths. One—one
16 small example that—that fits Chair Rivera's district
17 is somebody might have called a gouverneur for a
18 primary care appointment, and then being told there's
19 no appointment for six months, and because we
20 weren't—we had no information, nobody said, oh, but
21 by the way we have a phenomenal doctor at Judson, and
22 we actually have appointments there, but there—
23 because everything operated as its own thing, instead
24 someone would be put on a wait list for six months.
25 So, the system wasn't functioning as a system, and I

2 think that that's the area of greatest growth. So,
3 I—what I want, I think if you talk—well, certainly
4 what I've learned in talking to New Yorkers about
5 their view of Health and Hospitals, everyone is very
6 clear if something bad happens I want to go to
7 Bellevue. I want to go to Elmhurst. I want to go
8 Kings County, right. They know that through the ED
9 they're going to get great care, but can I get an
10 appointment for a pap smear? Right, well it
11 was…right, you know, can I—can I use my telephone,
12 you know, to just book myself for a pap smear?
13 That's the area where Health and Hospitals there is
14 quite a lot of work to do.
15 SPEAKER JOHNSON: Can you talk about how
16 the San Francisco and the My Health L.A. program. You
17 mentioned in your opening statement. What are
18 lessons from those programs that you all applied in
19 creating NYC Care?
20 DR. MITCHELL KATZ: Well, the—the biggest
21 lesson from them, which we applied was that you have
22 to build on the existing structures that you have
23 locally because if you just say well I want to create
24 something new, then you're paying for everything,
25 hospitalization, emergency room, primary care. So,

2 instead, what all three programs said is okay here's
3 what we have. How do we make it a lot better? How
4 do we tie it together? How do we do the system
5 stuff. I think San Francisco had the advantage of
6 having an employer spending mandate. It was Pre-ACA.
7 So, they didn't—wouldn't have the same requirements
8 of—that the ACA imposed about what insurance should
9 look like, and that provided a large influx of
10 dollars, and we were able to direct most of those
11 dollars to the federally qualified health centers.
12 So that was an advantage that we had in San
13 Francisco. In L.A. which the program was larger, hit
14 130,000 while San Francisco maxed at about 75,000.
15 Now is under 15,000, and Los Angeles is somewhat
16 different because they didn't have a group like all
17 of you, and so Los Angeles in their tough budget
18 moments basically eliminated half of its primary
19 care. It just closed it, and so there was—and—and in
20 that vain, basically said we can't o it, and so they
21 gave a—they closed about half the primary care and
22 gave the dollars that were supporting that, they gave
23 half of it federally qualified health centers and
24 other community clinics. Historically, this is maybe
25 like 15 years ago, and so when I did L.A. and—the

2 program there, there was already a large pot of money
3 that was supporting the Federally Qualified Health
4 Centers because the county had sort of given you that
5 as a mission, and so that program was about taking
6 the dollars that were going to the Federally
7 Qualified Health Centers already, and now the
8 community clinics and turning it into a—a
9 comprehensive care system that had been previously—
10 those dollars were used. Each visit a center got
11 paid for, but there was no empanelment. There was no
12 this was your doctor, and so, we took the dollars,
13 ands we turned it into, if you're going to this
14 center this is your place. And again, like a primary
15 care doctor, that's how I think. I want everybody to
16 know where to go, and other things to emanate from
17 that.
18 SPEAKER JOHNSON: So—so, FQHCs were
19 integral to those two programs?
20 DR. MITCHELL KATZ: They were—they were
21 to both.
22 SPEAKER JOHNSON: So, how come Federally
23 Qualified Health Centers are not part of NY Care?
24 DR. MITCHELL KATZ: Well, again, first I
25 do believe they're part of, um, NYC Care because we—

2 we are providing their specialty care, and because
3 we—we=we've included in the scripts to have people
4 recognize that their center is a good place to go to
5 care. I think compared to L.A. the biggest
6 difference is that there was no primary care. I
7 didn't have anything to build o in the public sector
8 because the public sector in its budget crisis had
9 given up primary care, and so I already had a large
10 set of dollars. It was not a new set I would say.
11 So I didn't—I did not provide new dollars. I took the
12 existing dollars that were going to them, and I
13 changed it into a guaranteed access program as
14 opposed to a fee for service, you go here. So, you
15 know, I'm happy to, you know, work with—with all of
16 you on sort of as-as this moves forward, you know,
17 how-how—how we include Federally Qualified Health
18 Centers. We love them. We want them to be part of
19 this. I think there's lots of room that we can do
20 great stuff together.
21 SPEAKER JOHNSON: We want to be part of
22 this, too, which is why we're having--
23 MARIELLE KRESS: Yeah, and I think that
24 you know that Gotham Health is the largest Federally
25 Qualified Health Center network in the country, too,

which is part of our system. So, absolutely, Federally Qualified Health Centers are included in NYC Car and Health and Hospitals as well.

SPEAKER JOHNSON: I mean, you know, I'm just—you don't have to respond to this, but I'm just going to make—make a statement. The Mayor has been going around saying he's provide universal healthcare access, and I think the reason why you're seeing this bill from—I think Chair Levine can speak to this, but the reason why you're seeing this bill from the City Council is that we don't think this is universal access. We're happy. We think it's great. We're glad was top to bottom in the State of the City earlier this year. We're supportive of getting more people access to healthcare, but to call it universal healthcare access, but to leave out what this bill seeks to fill the gap on, I think shows that it's not universal healthcare access, which is why we're having this hearing today, which is why we support this bill. Chair Levine can go into that a little bit further. I want to ask what do you see as the future of healthcare in New York City? We're seeing lots of people who are eligible for insurance, but can't afford deductibles or co-pays and there are

2 plenty of folks that just can't figure out how to
3 navigate their plans. So, what do we need to do next
4 to improve the odds that people actually get good
5 care in terms of affordability, purchasing power,
6 accessibility not just from H&H, but regardless of
7 where they go.
8 DR. TED LYON: Well, thanks, Speaker. It
9 gives me a second and for all of us to think about
10 it. One of the great things about the clinic I work
11 in at Gouveneur is a third of my patients are
12 undocumented. They have no insurance. A third of
13 them have Medicaid or Medicare. A third of them have
14 private insurance, and I can't tell you how extensive
15 the problems are with people who have private
16 insurance. In the case of one—one senior I took care
17 of, he went to the emergency room, got—got an inhaler
18 treatment, and he had a $50 co-pay, and so what did
19 he do? He didn't fill the prescription. When I saw
20 him several days later, he's more short of breath
21 than he started and he's insured, right. So, right,
22 not the group right. We, I mean we hear because of
23 your—how caring the City Council is to focus on
24 people who don't have what we would say don't have
25 access. They're uninsured. This is a guy, he's—he's

2 fully insured. He actually for his emergency room
3 visit he would have paid zero, but what good is it if
4 he—if the medicine costs $60 and he doesn't have $60,
5 and many people don't have $60. Um, and so,
6 ultimately for the sake of New York there really does
7 need to be a major change, and I-I think the—the
8 single payor legislation that it -that Chairperson
9 Rivera talked about that is being considered at the
10 state is the best option ultimately.
11 SPEAKER JOHNSON: How much is the cost of
12 an IC care?
13 DR. MITCHELL KATZ: Okay, so let me try
14 to answer that in a simpler way given the
15 complications. So, we—if you conceptualize the cost
16 of NYC Care as the things we added, right because so—
17 because remember that 7,500 people are getting all
18 kinds of services that we always provided. So, what
19 have we added? So, I told you we added—the $650,000
20 went the community-based organizations, and then we
21 have hired additional doctors. We have hired people
22 who support those doctors along with nurse
23 practitioners. We have expanded the pharmacy hours
24 to the 3,000 prescriptions. We have expanded the
25 hours of the Call Center, and we have while the—the

2 ad campaign was created pro bono we had purchased ads
3 in the—in the subways bus shelters and are doing
4 media things. So those—those are the additional
5 things. Those are the things for which the $100
6 million is meant to pay for as we roll out. My
7 colleagues at OMB are working on providing a figure
8 on what those costs are, and they are not yet there
9 in terms of providing detailed information.
10 SPEAKER JOHNSON: I—I do not mean this in
11 anyway to denigrate you, your leadership, H&H, the
12 program, but not to try to boil it down too simply,
13 but so outreach, pharmacy hours, a call center and
14 hiring equals guaranteed healthcare?
15 DR. MITCHELL KATZ: Well, the—the idea of
16 the guarantee right because obviously the amount
17 we've spent so far only reflects what we've spent in
18 the Bronx. I mean it's not -the idea was to grow into
19 universal because we saw as integral to this program
20 this commitment that you get an appointment in two
21 weeks. I don't—what I don't want this to be, and we
22 didn't have this in San Francisco or L.A. I don't
23 want waiting lists. I don't want unique care and
24 you're on the waiting list in six months. So, in
25 order to prevent waiting lists, and to keep the two-

2 week commitment, it has to grow in each borough, and
3 that's why we went first Bronx, next Brooklyn,
4 Staten Island and then we'll do Queens and—and
5 Manhattan, and so in each area that's how we grow.
6 So, at some point the expense will, I—I think be
7 near a $100 million. It certainly isn't there now.
8 SPEAKER JOHNSON: It will be $100 million
9 of new dollars?
10 DR. MITCHELL KATZ: Of new dollars.
11 SPEAKER JOHNSON: Of new dollars and—and
12 is that dollar or is the $100 million money that OMB
13 is giving to H&H or H&H is supposed to come up with
14 revenue or internal budget dollars that will be
15 dedicated to NYC Care?
16 DR. MITCHELL KATZ: No, that was OMB
17 allocated $100 million to the program.
18 SPEAKER JOHNSON: OMB allocated $100
19 million. Okay. When you joined just about two years
20 ago to lead H&H, if you could just remind us all what
21 was the financial position that H&H was in?
22 DR. MITCHELL KATZ: So, it was--the $1.8
23 billion deficit.
24 SPEAKER JOHNSON: $1.8 billion. That's
25 it?

2 DR. MITCHELL KATZ: That’s it.
3 SPEAKER JOHNSON: $1.8 billion and there
4 were significant DISH cuts on the horizon--
5 DR. MITCHELL KATZ: Correct.
6 SPEAKER JOHNSON: --that got put off--
7 DR. MITCHELL KATZ: Correct.
8 SPEAKER JOHNSON: --because of federal
9 intervention--
10 DR. MITCHELL KATZ: Correct.
11 SPEAKER JOHNSON: --from basically
12 Congress. They have to make that happen.
13 DR. MITCHELL KATZ: Correct.
14 SPEAKER JOHNSON: --and so where are we
15 today?
16 DR. MITCHELL KATZ: Right. So, um, the
17 first push-off took it from $1.8 to $1.5, and then
18 the things that we’ve been doing to decrease
19 administrative expenses, and to increase revenue have
20 gotten us about two-thirds of the—of the budget hole
21 is closed now. So, we have about a third, but we’re—
22 we’re on track to close the whole thing. I mean you
23 remember that, um, my strategy and Chair Rivera, um,
24 was very good at both helping me and helping people
25 to understand was always—it’s a multi-year plan.

2 From my point of view there is no more deficit. What
3 I mean by that is we—we—we have a plant that
4 eliminates it and so far we're on track. We're
5 actually a little a ahead of where we thought we
6 would be. So, the—the idea is as you get better at—at
7 revenue, and I want to be clear it's revenue from
8 insurance companies. It's not billing people. We're
9 not interested. People we take care of do not have
10 dollars to pay for healthcare, but Health and
11 Hospitals for a complicated set of reasons was not
12 good at billing insurance. We are basically giving
13 insurance companies a free ride. They were gaining
14 the insurance premiums and we were providing care for
15 free. It was a great deal for them, and not such a
16 great deal for the city. So, if we continue to hit
17 our—our milestones we will eliminate the deficit by a
18 bout year four.
19 SPEAKER COREY JOHNSON: When—when is your
20 four?
21 DR. MITCHELL KATZ: Two years from now.
22 SPEAKER JOHNSON: Two years from now.
23 DR. MITCHELL KATZ: Yeah.
24 SPEAKER JOHNSON: Two years from now and
25 then when do we start getting surpluses?

2 DR. MITCHELL KATZ: Well, I would assume
3 that—that we would always spend whatever money we had
4 on our patients. I don't know. I've never worked for
5 a group with surplus. [laughter]
6 SPEAKER JOHNSON: Got it. Okay, I have
7 some questions. Thank you, Dr. Katz. I have some
8 questions for DOMH if they would like to come up.
9 I'll try to get to his quickly, um, because I want to
10 move to the other chairs, but I want to start by—talk
11 about some of the work the Administration has done on
12 health access prior to NYC Care. Let's start with
13 the 2015 Immigrant Healthcare Task Force, which was
14 created with the goal of increasing access to
15 healthcare services among immigrant populations and
16 identified major barriers to healthcare access
17 including inadequate cultural and linguistic
18 competency among providers in limited provider
19 capacity. That task force said the best way to
20 address there barriers was to create direct access
21 healthcare program. A year later the Administration
22 launched a one-year pilot called Action Health NYC
23 for low-income residents who were uninsured and not
24 eligible for health insurance. Those in the pilot
25 have care coordinators and use both HQHCs—they use

2 both HQFCs and H&H facilities to get primary care.
3 After the pilot ended, the Council received an
4 evaluation, but it didn't include any
5 recommendations, which is really bizaar. There was no
6 assessment of scalability, nothing on the extent of
7 need or revised costs. Why did the City Council not
8 get any of these recommendations?
9 MALE SPEAKER: Thank you Speaker for that
10 question, and the Action Health Demonstration Program
11 as you mentioned was a year-long demonstration
12 program, which was meant to have a robust independent
13 evaluation. So the Department of Health along with
14 our partners at Health and Hospitals, the Mayor's
15 Office of Immigrant Affairs, and other city agencies
16 contracted out the evaluation to a third party. That
17 report that was made available to the Council as well
18 as all our other partners was meant to be an
19 independent evaluation that showed whether or not
20 certain aspects of Action Health worked. So, after
21 that report was—was finished and made public, Health
22 and Hospitals used it to inform the development of
23 NYC Care.
24 SPEAKER JOHNSON: With the
25 recommendations?

2 MALE SPEAKER: In the actual evaluation
3 form the American Institute for Research there were –
4 there—any recommendations came directly from the
5 American Institute of Research. The task force had
6 ended at that point.
7 SPEAKER JOHNSON: Do you think that it
8 was a thorough evaluation?
9 MALE SPEAKER: Yes.
10 SPEAKER JOHNSON: But I'm confused. If—
11 if there were insurmountable challenges, why weren't
12 they mentioned in the evaluation?
13 MALE SPEAKER: So the evaluation was very
14 specific to elements of Action Health that were being
15 evaluated, and the program at those primary care
16 homes that you mentioned.
17 SPEAKER JOHNSON: Why wasn't the pilot
18 extended?
19 MALE SPEAKER: So Action Health was meant
20 to be a year-long demonstration where we were looking
21 for learnings to inform the Administration's strategy
22 on what uninsured access to care would look like.
23 SPEAKER JOHNSON: Why weren't HQFCs
24 included at the time?
25

2 MALE SPEAKER: As Dr. Katz mentioned a
3 key part of NYC Cares as well as Action Health is
4 building on the primary care home model and that
5 relationship with health professionals or with your
6 primary care provider, and so what we did when
7 Action—in Action Health was we included community
8 partners including FQHCs that based on where the
9 Action Health model was rolled out. In that case, it
10 was in two neighborhoods in Queens.
11 SPEAKER JOHNSON: Well, let's be clear.
12 That's not what NYC Care is doing, and what—and what
13 the actual model did.
14 MALE SPEAKER: So, so I, you know, defer
15 to my colleagues at Health and Hospitals on the
16 specifics of NYC Care, by NYC Care is building on the
17 learnings from Action Health which includes the fact
18 that there was a primary care home model included.
19 SPEAKER JOHNSON: Did anything about the
20 pilot contribute to the decision not to include FQHCs
21 in NYC Care?
22 MALE SPEAKER: So, I defer to Dr. Katz
23 on—on questions about NYC Care.
24 DR. MITCHELL KATZ: No.
25

2 SPEAKER JOHNSON: The pilot ended in June
3 of 2017 and NYC Care wasn't launched until the summer
4 of 2019. That's a pretty big gap. Why is that?
5 MALE SPEAKER: So throughout that time at
6 the Health Department we were certainly having
7 conversations with our partners across the
8 Administration on what the best strategy to improve
9 access to healthcare for immigrant and other
10 populations.
11 SPEAKER JOHNSON: You worked on the task
12 force?
13 MALE SPEAKER: I did.
14 SPEAKER JOHNSON: So the recommendations
15 of the task force were pretty clear that a direct
16 access program is the best way to address barriers in
17 getting good care. Is the Administration disavowing
18 those findings now?
19 MALE SPEAKER: I don't believe the
20 Administration is disavowing those findings. NYC
21 Care is a program that builds on learnings from
22 Action Health and the recommendations from the 2014-
23 2015 task force.
24 SPEAKER JOHNSON: Did you or anyone at
25 DOHMH make and recommendations to City Hall about how

2 a health—how a health access program should work
3 before they rolled out NYC Care?
4 MALE SPEAKER: So, we are constantly—at
5 the Health Department we are constantly working with
6 our partners at Health and Hospitals, and City Hall
7 and other agencies to talk about how to improve
8 access to care. So, those conversations have been
9 going on since the beginning of this Administration.
10 SPEAKER JOHNSON: Do you think that this
11 is a good bill that we're hearing today given what-
12 MALE SPEAKER: [interposing] So, at the
13 Health Department we support universal access to
14 health insurance and universal access to healthcare.
15 SPEAKER JOHNSON: So you think this is a
16 good bill?
17 MALE SPEAKER: We support the intent of
18 the bill. We at the Health Department are always
19 interested in improving access to healthcare for all
20 populations.
21 SPEAKER JOHNSON: But do you think that
22 this improves access to healthcare for vulnerable
23 populations?
24 MALE SPEAKER:
25 SPEAKER JOHNSON:

2 MALE SPEAKER: So, I don't want to speak
3 to the specifics of the bill, but we do
4 SPEAKER JOHNSONS: But you're here today
5 to testify on a bill. That's why we called you.
6 That's why we called the Health Department here
7 today.
8 MALE SPEAKER: So, we're not--
9 SPEAKER JOHNSON: [interposing] To not
10 talk about intent, but to actually talk about what
11 the bill is. That's why we've waited so long to have
12 the hearing, and communicating with the
13 Administration. It's not about conception here or
14 concept. It's about actually getting to the nitty
15 gritty. You worked on the Task Force. You were
16 involved with Acton Health, which included FQHCs. You
17 were a point person in that. You were advising City
18 Hall, as you just said on continuing to expand
19 healthcare access. So, given all those factors, I
20 would like to know what in this bill you think in any
21 way is problematic?
22 MALE SPEAKER: So, we are certainly happy
23 to have conversations--
24 SPEAKER JOHNSON: [interposing] Well,
25 we're having conversations publicly at a hearing not

2 private conversations. That's what the hearing
3 setting is for. So, I would—I'd like to understand—
4 we've shared this bill with you for a long time. You
5 worked on the Task Force, you worked on Action
6 Health. You said you are advising City Hall on
7 rolling out NYC Care and creating the Universal
8 Access Program. I'd like to understand what things
9 you think in this bill are problematic?
10 MALE SPEAKER: So, we are, um, as I said,
11 Speaker, we are absolutely interested in having
12 conversations not just with the Council, but with all
13 of our community partners on the specifics of the
14 bill and on how to get to universal access and how to
15 improve access to healthcare. That's something we've
16 been doing for years that we're constantly doing with
17 Health and Hospitals, but we are not—we do not have—I
18 Do not have answers on specific provisions of—of this
19 bill, but when it comes to those conversations, we're
20 more than happy to have those conversations, and I do
21 want to stress that we are constantly working with
22 our partners across city government to—to figure out
23 how we can improve access to healthcare.
24 SPEAKER JOHNSON: Okay, but—the
25 Administration has been going around saying that NYC

2 Care is a universal healthcare access plan. You're
3 advising them or you have advised them in your role
4 at DOHMH in your previous roles. You have the bill in
5 front of you today because we do not believe it is a
6 universal access program, and this happens time and
7 again with the Administration where we have hearings,
8 we share bill far ahead of time. We are in constant
9 communication with agency staff and with other staff,
10 and then we come to a hearing, and we aren't getting
11 direct answers. The answers that we need are for the
12 advocates that are in the room today for the press,
13 for the Council Members that have taken time out of
14 their busy schedule to be here. So, that is why I
15 expected that the Department of Health, which is the
16 largest public health agency in the city of New York,
17 would show up today with actual granular specific
18 feedback on this bill, and I think it's shocking that
19 that's not the case. So there's nothing you want to
20 say specifically about the Council's bill that we're
21 hearing today?
22 MALE SPEAKER: So, at the department we
23 support NYC Care. We think it was strategically
24 developed, and we support the administration and
25 Health and Hospitals' efforts to implement NYC Cares.

2 It was implemented and designed based on the
3 learnings form Action Health. Our colleagues at
4 Health and Hospitals are thoughtful about how they
5 not just roll out NYC Care, but other initiatives
6 that impact people's access to healthcare, and so I
7 don't' want to get into the kind—the specifics of the
8 bill because my colleagues at Health and Hospitals
9 are rolling out NYC Care, which is the—the largest
10 program of its kind, will be the largest program of
11 its kind in the country and it builds on the
12 learnings from the Task Force and Action Health. So,
13 Dr. Katz may have more to say about the specifics of
14 what those plans look like, but we are supportive of
15 those at the Health Department.
16 SPEAKER JOHNSON: So, you don't think
17 it's problematic that there is no site on Staten
18 Island?
19 MALE SPEAKER: So, we—we are just like
20 our colleagues at Health and Hospitals want access to
21 healthcare for people across the city. So, there are
22 healthcare providers. I understand there is no acute
23 care facility from Health and Hospitals on Staten
24 Island, but there—we are certainly supportive of
25

having access to healthcare for people across the city.

SPEAKER JOHNSON: That's what this bill does. I'm very confused. Okay, I'm going to turn it back to Chair Levine.

CHAIRPERSON LEVINE: Thank you so much Speaker Johnson. I see you haven't forgotten everything from your days as Health Chair. Good to know. I—I want to emphasize that we consider NYC Care to be a welcome and important step forward, but this is our shot to do this right, to go big, to become comprehensive, to reach everybody who is currently being left behind by the mainstream radical system. The numbers are huge, probably a half million people in the city who don't have health insurance, and most of them are not going to be able to enroll in the publicly subsidized plan no mater how much outreach that we do, and they are in every single neighborhood of this city. They are in every single community board of the city, and at a time when we have a Mayor and a Council that are in agreement on the principle of Universal Healthcare, we feel really strongly we have to do this right. We might not have an opportunity like this again, and so

2 I—I do want to remind everybody just what this FQHC
3 movement is in that context. I know you know this,
4 but, you know, these—this is a movement that emerged
5 out activists in the Civil Rights Era that wanted to
6 take healthcare out of big—out of such institutions
7 into the neighborhood where low-income people, people
8 of color and immigrants have often been suffering in
9 isolation. This is a non-profit sector. This is a
10 sector deeply rooted in the very communities of color
11 and immigrant communities that they are serving.
12 This is a sector where cultural competence and multi-
13 linguality are just totally in the DNA, and when I
14 heard you describe kind of the components of good
15 healthcare, I wrote down some of the words. You
16 talked about the importance of relationships and
17 trust. You talked about the importance of proximity,
18 geographic proximity for primary care, and you talked
19 about building on existing structures. We have an
20 existing structure of 500 community-based clinics
21 that-that embody all these values that you quite
22 eloquently expressed, and I'm trying to understand
23 why they weren't included in NYC Care, and the only
24 possible explanation, one which I also don't accept--
25 and I'll talk more about that--but the only possible

2 explanation would be an objection based on cost. Is
3 that the basis of the Administration's objection to
4 including these institutions?
5 DR. MITCHELL KATZ: Well, again I do
6 disagree in the sense that I feel that Federally
7 Qualified Health Centers are part of it, but you're
8 right that we're not paying them. So, and-and we did
9 deal with this issue in—in Los Angeles, and San
10 Francisco, and there are people here in this room
11 even more expert. There are complicated issues about
12 paying, that local government is paying federally
13 qualified health centers for care because of the—the
14 mandate that the higher rate of reimbursement of an
15 FQHC for the Medicaid population is meant in part
16 because of the care of people who are uninsured, but
17 I don't see this as an insurmountable barrier or
18 something that we can't together make happen> The—
19 again, I--the—the-the—the only thing that, um, that
20 we haven't done is we haven't sent dollars. I mean
21 we—we—we met with the FQHCs, We—we--I totally
22 understand like the last thing I would want is if
23 someone has a great relationship with their
24 federally qualified health center doctor or nurse
25 practitioner, they hear about this program, and they

2 think they have to disenroll, and that's why we were—
3 we worked with the FQFCs. Let's make sure the
4 scripts say: No. Keep going to that center, and come
5 to us for specialty care, and while we put so much
6 effort into how do we make that specialty care really
7 work? How do we pay like FQHCs can do the primary
8 care medications, but they can't do the Rhuematologic
9 agents because they are figured in the budgets of
10 some FQHCs, some of those drugs. So, but I—I—I
11 totally understand, and I—and I see there is a—
12 there's a road forward here, um, and I think
13 certainly I'd like to focus on, you know, walking
14 that road with all of you.
15 CHAIRPERSON LEVINE: Okay, you—you didn't
16 exactly take the bait on the cost issue, and, um, I—I
17 want to have that discussion. I—I believe that the
18 stakes here justify a robust investment in this,
19 especially if as the Speaker mentioned we're going to
20 live up to the promise of being a truly universal
21 healthcare system. That's not going to be cheap, and
22 I want to emphasize something you know, and you've
23 articulated that every dollar we spend upfront on
24 prevention in a primary care setting is going to save
25 us, save H&H money from avoiding crisis cases that

2 land in the emergency room, which first and foremost
3 is bad for patients, but also imposes a financial
4 burden on the Health and Hospital system, but I do
5 want to push back on this notion that the FQHCs are
6 included. If—if I'm an Asian immigrant in Flushing,
7 and I hear reports of—lf the same kind of NYC Care,
8 and I—I look up the terms of the program, I'm going
9 to learn that there's no eligible facilities in my
10 community. I don't think H&H has a facility--
11 DR. MITCHELL KATZ: Correct.
12 CHAIRPERSON LEVINE: It's a—I think
13 that's the biggest concentration of immigrants in
14 Queens probably one of the biggest in America, but
15 then there's something called Charles B. Wang
16 Community Health Center that is in multiple
17 neighborhood Flushing being one of them and, you
18 know, that--that Asian immigrant is going to know
19 Charles B. Wang, they're going to know that they will
20 speak their language any of the variety of Asian
21 languages. There's going to be a level of trust there
22 that they might not feel elsewhere, and this is all
23 about reducing barriers for people who are scared
24 right now. In the Trump era they're scared of being
25 institutions. They're scared of government, and we

2 have to do everything we can to make them feel
3 comfortable, and non-profits like Charles B. Wang are
4 not one of the places that you can go with the NYC
5 Care Card currently to get your annual physical, to
6 get your vaccinations, to get your referrals to
7 specialists. Is that not accurate?
8 DR. MITCHELL KATZ: Well, again, so, I—I
9 think it's a wonderful very qualified health center,
10 and they would certainly--and they should speak for
11 themselves--they would do those things now. So, I
12 think the question then on it right. So if someone
13 calls that clinic they're going to provide that
14 service for that person. That is their mandate as a
15 federally qualified health center to not say not. I
16 think if New York has the ability to also provide
17 additional funding, that would be a great thing.
18 I'll say for example in health—when we did Healthy
19 San Francisco we were very careful that the dollars
20 were articulated for the administrative costs of the—
21 the FQFC taking the person in not for the care
22 because what we heard rom their FQHC colleagues is
23 that if you're receiving 330 federal funds for taking
24 care of uninsured people in your program, you can't
25 be receiving other funds. So there are—but there—

2 that's a—there is a road here. There are—we did
3 provide them support. We didn't provide them support
4 for the care. We provided them support for the
5 wraparounds, and I can see how we could do that here,
6 too. I just want to be clear that—that some of this
7 is complicated because of the rules, and again, the
8 people in this audience much more articulative about
9 talking about FQHC rules than I am.
10 CHAIRPERSON LEVINE: Right and thank
11 goodness we live in a city that doesn't turn people
12 away in healthcare institutions. That, by the way is
13 not new, but it—it is—it's a core value to New York
14 City that we're all really proud of, but still, there
15 are hundreds of thousands of people who are not
16 coming in for primary care. They're not getting
17 annual physicals--
18 DR. MITCHELL KATZ: Right
19 CHAIRPERSON LEVINE: --and that is dire
20 health consequences for them and for broad—broadly
21 speaking, public health, and the whole idea of NYC
22 Care and the programs that you created elsewhere is
23 to reduce the barriers to build trust, to build
24 support systems, to have people guided into these
25 services not because they don't already exist, but

2 because for a variety of reasons people aren't
3 accessing them and, you know, you get an NYC Care
4 card I think it has prices listed even on the card or
5 in supporting documentation. Those are the prices
6 for H&H, and they don't apply in Charles B. Wang or
7 any FQHCs. They're out of whack. It's just one more
8 way in which the system is not seamless until
9 everybody is under the same umbrella, until we can
10 unify pricing, until we can unify referrals, and—and
11 the that is not the way the structure of the program
12 is currently. I want to ask you about the resources
13 within H&H. It's so important that as you've now
14 brought in 7,500, which is—which is a significant
15 number and for what I commend you for achieving in
16 the early months, you're going to need to have the
17 staffing to serve them. And even before you launched
18 NYC Care, we have had serious concerns about adequate
19 staffing in your facilities especially not only, but
20 especially among nurses who are really over-burdened
21 right now, and have excessive patient loads, and that
22 has implications for the staff, but also for our
23 patients, and you know this impacts health outcomes.
24 So, I'm worried now that as you're adding an extra
25 load on some of your facilities that already

2 overstrain staff including nurses, all the frontline
3 providers are only going to be more strained. Can you
4 assure us that this is not happening?
5 DR. MITCHELL KATZ: Sure. Well, first,
6 Chair, you were right. My impression when I first
7 got here is that there was inadequate nurse staffing,
8 and I've been very clear that that's true, and that
9 we should—that we have to address that, and we have—
10 we in the first year added 330 nurses despite, you
11 know, trying to close the deficit and we're going to
12 add more nurses in this year, and that has to happen
13 no matter what happens with this program. The—we are
14 also aware and we want—we're working with our great
15 colleagues at NYSNA to fix the fact that we have—we
16 will hire new nurses, but often the salary structure
17 is such that after two or three years, we're totally
18 non-competitive with the rest of the market, and so
19 we devote a lot of money to training nurses. It can
20 take nine months to train an ICU nurse, and then we
21 might lose him or her at year 2 or 3, which is yet
22 another kind of loss to us, right? Not to mention
23 that you can't possibly provide great care if all
24 your nurses are new. It's good to have new nurses,
25 and it's good to have really experienced nurses and

2 have them all be together. So, you know, I—I-I
3 totally agree with your assessment. The idea of the
4 program and the reason we are rolling it out in this
5 way has always been figure out what the workload will
6 be, and staff up ahead in time so that so far no I
7 can guarantee you that so far the 7,500 people have
8 not resulted in the kinds of problems, but—but I work
9 on it with Marille and Dr. Long on it everyday,
10 right. Like do we have enough access? Can we make
11 this happen? And I've told them specifically even
12 with the goal, look, at the end of the day, these
13 were goals. Right? Don't provide bad care. If we
14 can't—if we can't hit the goal, then we're not going
15 to hit the goal, but we're not going to provide bad
16 care. So, I mean I—this is a work in progress. I
17 like your ideas about how we, you know, make this
18 broader. You have my commitment that if I felt that
19 we did not have enough staffing, I would be back here
20 or I would be saying, look, this program has to go on
21 hold until we as collective city figure out how to
22 fund it. I don't believe in doing things badly.
23 CHAIRPERSON LEVINE: There—there-there
24 are a lot of ways in which the public hospitals are
25 essentially subsidizing our voluntary hospitals.

2 DR. MITCHELL KATZ: Correct.

3 CHAIRPERSON LEVINE: You sever more

4 uninsured patients. You and you serve more behavior

5 health patients, and other cases which are not

6 profitable, and the voluntaries are relying on—on

7 this, but I don't think we pay enough attention to

8 the extent to which they're also a training ground

9 for great staff that are now hired away at higher

10 salaries, and—and I—I'm sympathetic your point on

11 that. When—when—when we raise salaries hopefully

12 that gap will close, but there's another important

13 way that you can keep your staff longer, staff that

14 is committed to being in public hospitals. They're

15 there because they believe in the mission that for

16 the same reason that you and your team are in public

17 hospitals. They believe in the mission, and one way

18 you can ensure that you keep them that they don't

19 burn out is that they have adequate patient loads.

20 DR. MITCHELL KATZ: Right.

21 CHAIRPERSON LEVINE: This is a—this is a

22 critical way you will retain staff longer. It's first

23 and foremost good for patients, but also it's good

24 for the staff as well. The last question and then

25 I'll pass it on. The Mayor's Management Report, the

2 MMR this year listed something that I haven't
3 understood, but I just want to give you a chance to—
4 to help us understand. In 2018, the H&H system saw
5 about 1,112,000 patients and in 2019, the system saw
6 1,0080,000, and um, can you explain that drop in
7 patients given all the important expansion in
8 services that you have implemented?
9 DR. MITCHELL KATZ: Sure. So, Health and
10 Hospitals, and this is one of our weaknesses has
11 always been a hospital system, and hospitals across
12 New York State are experiencing decreased volumes,
13 and that's mostly a good thing. Childhood
14 vaccinations, right. When I was a resident every
15 hospital had 30 patients who were in the pediatric
16 ward. Now, we often have one or two because
17 childhood immunizations have eliminated the need to
18 have hospitalized—to hospitalize kids. So, we in all
19 systems are experiencing a decrease in hospital
20 volume, and I'm happy about that, but it doesn't in
21 any way negate your points about the person out there
22 Dr. Long saw as part of the program a gentleman in
23 the Bronx who had not seen a doctor for 40 years had
24 their first visit in 40 years through NYC Care. So,
25 what we want to be is a system of primary care access

2 that addresses the issues you saw articulately talked
3 about that prevents illness, and I'd be thrilled if a
4 future management report showed those numbers even
5 lower, but I want the—the lower hospital numbers to
6 be next to more primary care visits, more Pap smears,
7 more colon cancer screening, lower blood pressures
8 that are Hemaglobin A-1Cs, more people getting, you
9 know, either young women if they want to become
10 pregnant getting folic acid and health guidance. If
11 they don't want be getting pregnant, getting long
12 acting birth control. That's where we should be.
13 That's—that's the place. You know, let the volumes
14 of the hospitals drop. Let us do a better job. I'll
15 just add one thing because you had mentioned it.
16 Behavioral Health. So, you're aware this is a city
17 with—with large numbers of huge successful non-profit
18 systems. We at H&H we do 60% of the behavioral
19 health for the city. The rest of the city hospitals
20 do 40%, right. What better example could there be of
21 the subsidy? Why is that? Because mental health
22 services are not well reimbursed. So, we keep doing
23 it, and we'll keep doing it, and I'm proud to keep
24 doing it. That's our mission, but it's essentially a
25 subsidy, right, because the other hospitals have

2 gotten out of that business because no matter how
3 efficient you are, you can't break even. You do it,
4 you do it out of mission. You don't do it as a
5 business.
6 MARIELLE KRESS: And if I may underscore
7 something that Dr. Katz said, I think NYC Care is
8 really trying to fundamentally change the way that
9 we're providing care to our uninsured patients. We
10 know that half of our uninsured patients only come to
11 see us through the Emergency Department, and we agree
12 with you that the backbone of the Healthcare System
13 is Community Health Centers, and so we're really
14 investing in our Gotham Health Centers. We have
15 planned for three new large beautiful Community
16 Health Centers across the city over the coming years,
17 and I think that, you know, we agree with your
18 sentiment that that is really where we ant people to
19 receive care in the community with additional
20 providers that will be able to hire and their care
21 teams through this programs.
22 CHAIRPERSON LEVINE: Thank you very much
23 and I'm going to pass it off to Chair Rivera. Thank
24 you.
25

2 CHAIRPERSON RIVERA: Hello. I know we
3 have a lot of advocates and people waiting to
4 testify. So, I'm going to try to blaze through some
5 of these. So, I would ask that be brief. Okay? So,
6 Dr. Katz, I bring this up to you every time in terms
7 of transparency with Health and Hospitals, and trying
8 to have a great relationship of trust and making sure
9 that we're getting some of the documentation that
10 we're constantly promised and committed to, and we
11 still really haven't received any of the financial
12 documents that were—that we-that we were expecting
13 during budget negotiations, and we didn't place any
14 terms and conditions on H&H because we decided that
15 we were going to let you kind of provide these
16 documents to us, and—and NYC Care is no exception in
17 that we don't really have any numbers. So, I'm going
18 to ask you a few questions about some of the numbers,
19 staffers, salaries, a lot of things that are unknown
20 that I think should be public information. Everyone
21 knows how much you make, right, Dr. Katz? They know
22 how much I make, so we're going to talk about. So,
23 how many staff have been hired to work on NYC Care
24 specific tasks?
25

2 MARIELLE KRESS: So, we've—so I've been
3 hired. We've hired some other administrative
4 staffers as well.
5 CHAIRPERSON RIVERA: How many?
6 MARIELLE KRESS: I believe we have three
7 total, and we've also hired staff to staff the 24-
8 hour Call Center.
9 DR. MITCHELL KATZ: What would you
10 estimate the number?
11 MARIELLE KRESS: For the Call Center?
12 CHAIRPERSON RIVERA: Uh-hm.
13 MARIELLE KRESS: Approximately 50 full-
14 time equivalent staff.
15 DR. MITCHELL KATZ: Clinical staff, how
16 many clinical staff would you say we added?
17 MARIELLE KRESS: We expect across the
18 city to add 60 care teams. So the primary care
19 providers and then the teams that support them to
20 provide care, um, to the patients that we expect to
21 come through our doors through the program. I don't
22 have the specifics on the—the number of providers,
23 but I know that in the past number or years we've
24 been able to hire 37 primary care providers and I
25 wonder if DR. THEDORELONG: can jump in here as well.

2 CHAIRPERSON RIVERA: Wait. I just want a
3 little bit of clarity. The 37 primary care doctors
4 is something that in your mission to kind of restore
5 the reputation of H&H, Dr. Katz, you have not only
6 hired more nurses, you hired more primary care
7 physicians. That's part of the larger mission of you
8 coming in and really trying to change up and close
9 this deficit. Do you—for NYC Care specifically we
10 have the three kind of administrators, the 50 call
11 center employees, and then you said 60 care teams?
12 Can you--
13 DR. MITCHELL KATZ: [interposing] But
14 that's for the whole—that's when rolled out.
15 MARIELLE KRESS: Right.
16 DR. MITCHELL KATZ: By 2020, there will
17 be 60 teams.
18 CHAIRPERSON RIVERA: By 20.
19 DR. MITCHELL KATZ: And tell the Chair
20 how many—what constitutes a team.
21 CHAIRPERSON RIVERA: Yeah, I'd love to
22 hear about it. I'd love to, love to.
23 DR. MITCHELL KATZ: Okay, Doctor.
24 DR. THEODORE LONG: Yes, I can then fist
25 answer you question. Good to see you.

2 CHAIRPERSON RIVERA: Hi.

3 DR. THEODORE LONG: About, um, the 37

4 primary care providers. So that was with our Docs

5 for NYC Care campaign where we identified after Dr.

6 Katz had been here for about months. So, it was a

7 critical issue, and we needed to get the providers we

8 need for our existing patients. We set out to hire

9 70 primary care providers. The number 37 comes from-

10 even in the first half of that period alone we were a

11 bit ahead of schedule so that's where we publicly

12 announced that. Since then we're pretty close to

13 hitting that—that number. The Primary Care Team as

14 I'm a primary care doctor myself so I have a

15 dedicated PCA to me, and then we have nurses that

16 operate at the top of their scope and honestly I

17 think the best nurses in the world that are, um, part

18 of each Primary Care Team, a certain number of nurses

19 per every four primary care providers. We also have

20 different other members of the team to social workers

21 who focus on depression care, social workers who

22 focus on social determinants of care, and now prior

23 to I'll say clinical pharmacists, but every time we—

24 we hire a new provide, including for NYC Care, we

25 have to have every other member of the team there

2 because I can't do it alone as a primary care
3 provider. So, as soon as we get each provider
4 identified we fill in the rest of the team as well.
5 CHAIRPERSON RIVERA: I'm going—I'm going
6 to ask about the community provider in a second, but
7 is NYC Care changing nurse-to-patient staffing ratios
8 at all with this rollout considering that you've
9 enrolled 7,500 people because there is an incredible
10 campaign going on by—by NYSNA to make sure that we
11 finally get safe staff and ratios in our hospitals,
12 and I want to make sure that as we are doing more and
13 more outreach, that we are looking at those numbers
14 to finally get them at the level that—that are safe
15 and that are—are practical.
16 DR. MITCHELL KATZ: So in transparency,
17 when I arrived there were no nurse ratios or nurse
18 staffing. Every hospital was staffed and every clinic
19 based on whatever historically it was, which
20 sometimes was great and sometimes wasn't great, but
21 whatever it was, it was, and if there were five
22 nurses due there and three were out because of they
23 had to be, the new two nurses and there was no—there
24 was no sense. So, we began the hard work of every
25 ward has to have a true nurse ratio. The ratio has

2 to be based on the severity of the illness. So,
3 we've now finished ratios for every single in-patient
4 ward. We're working now on ED, and think that—have
5 they now finished the outpatients—
6 DR. THEODORE LONG: Yes.
7 DR. MITCHELL KATZ: --or are you still
8 working on it? And they'd done the outpatient.
9 DR. THEODORE LONG: Yes.
10 DR. MITCHELL KATZ: So, the idea is that
11 every clinic has a ratio of how many nurses are
12 needed in order to care for the patients that wee
13 have Safeway, and we will work hard to implement it,
14 and we also, you know agree with NYSNA that unless
15 you provide adequate nursing, then the care is not
16 safe.
17 CHAIRPERSON RIVERA: In your testimony,
18 Dr. Katz, you say going to the community provider
19 piece that that non-Health and Hospitals FQHCs
20 developed a call center process and scripting for
21 Health and Hospitals to ensure that their patients
22 were redirected back to them. We have since met with
23 them again to ensure the process is working.
24 Additionally, primary care providers external to the
25 Health and Hospitals system are-are listed as

2 community provider on NYC Cars members' cards. What
3 to you consider a community provide?
4 DR. MITCHELL KATZ: I'm going to pass
5 that to Long.
6 DR. THEODORE LONG: Yeah, so a community
7 provider for us would be a provider at another FQHC
8 who has a sustained relationship longitudinally with
9 the patient, and may be coming to us just for
10 cardiology care. So, if the patient is being
11 referred from one of our excellent FQHCs to Lincoln
12 Hospital for cardiology, we would enroll them in NYC
13 Care so they could see what their cardiology visit
14 and cardiology related medication payments will be so
15 we demystify all of that, but we don't want to put on
16 the card a primary care provider in our system
17 because we want them to stay with their longitudinal
18 great relationship or primary care that they have at
19 the existing FQHC that they come from.
20 CHAIRPERSON RIVERA: How are you working
21 with some of the community-based organizations that
22 have been doing this work for such a long time, and
23 specifically when it comes to patients who I guess
24 are under 19, the number of uninsured children, we'll
25 call them, is on the rise nationally especially in

2 states that did not expand Medicaid under the ACA,
3 but I know that for New York we've actually gone down
4 a bit.
5 DR. MITCHELL KATZ: Yes.
6 CHAIRPERSON RIVERA: I think fifth in the
7 nation.
8 DR. MITCHELL KATZ: Right.
9 CHAIRPERSON RIVERA: But still, how do we
10 reach that 2.5% I think it was in 2018 of children
11 who are not ensured? Are you utilizing these
12 relationships and making sure that there are
13 resources for our community-based organizations
14 because they're the ones with the best relationships.
15 DR. MITCHELL KATZ: Sure. Do you want to?
16 You are going to take that?
17 MARIELLE KRESS: I mean I think we want
18 everyone across the city to have access to health
19 insurance regardless of their age, regardless of
20 their income, regardless of their immigration status,
21 and we have partnerships with these five community-
22 based organizations in the Bronx to speak a total of
23 10 different languages, who have relationships with
24 families who can counsel them on what is available t
25 them in the community whether that's health insurance

for their children under age 19, as you mentioned, or if they are ineligible for health insurance for those folks over age 19 NYC Care as well.

CHAIRPERSON RIVERA: So, you have a—you are—you have someone focused on a community outreach plan that is uplifting some of these community-based organizations, correct?

MARIELLE KRESS: Absolutely. Uh-hm, yeah.

CHAIRPERSON RIVERA: Are you in charge of that? Who is the person? This is one of the three administrators?

MARIELLE KRESS: Yes. I oversee the—the program and its operations including the outreach work as well. We have someone who works on strategic communications, someone who works directs our operations and someone who works on our community partnerships as well.

DR. MITCHELL KATZ: Uh-hm.

CHAIRPERSON RIVERA: Is there a metric for how H&H determines the average cost per uninsurable member of NYC Care?

DR. THEODORE LONG: It can be done. We don't—we don't currently do it. You'd have to, um, now that though that we have ethics we probably

2 could. For the first time, you know, we're going
3 live—once we go live in December at Kings, everything
4 will be live because the—the—previously all data
5 would have exited on different computers. So, how
6 would you ever figure out all care, but now we can
7 un-duplicate so we can, in fact, look at any one
8 person. Of course, they would still miss care they
9 received in other places, right. So, like a
10 Gouveneur patient that I saw yesterday brought me the
11 Ultrasound that she had gotten when she went to Mount
12 Sinai. So, those, right there will always be other
13 things, but—but, yeah, now we could.
14 CHAIRPERSON RIVERA: As you roll out in
15 other boroughs for example have you identified the
16 CBOs you're going to work with in Brooklyn and Staten
17 Island?
18 DR. THEODORE LONG: There's an RFP out
19 now for them to apply and we—we—we're sure we're
20 going to get as promised from the group that we had
21 in the Bronx.
22 MARIELLE KRESS: Applications are due on
23 November 8th.
24 CHAIRPERSON RIVERA: November 8th. Great.
25 I wanted to, um, ask you—I wanted to ask specifically

2 on some of the—how many languages does the staff
3 speak? How many new medical staff has been hired? I
4 mean these are—these are details that we're lacking.
5 I also am a little concerned at the financial data
6 that again that we're lacking and I know you
7 mentioned that OMB is working on it. Do you not think
8 that OMB is doing all of us a disservice by not
9 providing that financial data as frequently as
10 possible so we can be—look at it and analyze it, and
11 try to support you because the Health and Hospital
12 system is so incredibly important to all of us here,
13 and we want to make sure that we're able to—to
14 support your work.
15 DR. MITCHELL KATZ: I—I appreciate that
16 and I feel supported, and I will keep working with my
17 OMB colleagues. I—I certainly believe in transparency
18 and that the board should see the numbers. We'll
19 continue to talk with them about getting them those
20 numbers.
21 CHAIRPERSON RIVERA: We want you to
22 succeed.
23 DR. MITCHELL KATZ: I appreciate that
24 CHAIRPERSON RIVERA: Absolutely. So I
25 want to ask because you have this kind of mission and

2 this will be I guess.—I in know we have a couple of
3 members that have questions. Because you have kind
4 of this mission, and much of it is very practical,
5 which I appreciate, which is the billing ad the
6 coding and the Epic System, which is—which is we're
7 going to have a hearing on that soon. You mentioned
8 that this also covers a broader list of services, but
9 my question to you is what services are you having
10 the least success billing the insurance companies
11 for?
12 DR. THEODORE LONG: The—our biggest
13 problems with insurance companies are that they don't
14 understand social determinants. They don't
15 understand that I might be able to send you home on
16 day two of you're having pneumonia because you have a
17 loving family, and that I can't send home somebody
18 who has no one to bring them food or help them to a
19 bathroom. To the insurance company it's pneumonia.
20 Two days they should be out. Why are they still
21 there? You know, we won't approve the day. We—we
22 took care of, and I was very proud of this and it
23 was—I won't mention anything about the personal
24 details, but it came to us through an advocate. We
25 took care of somebody at H&H who was sent out an

2 amazing hospital system with two broken arms from the
3 emergency room, an elderly woman. Now, how are you
4 supposed to manage at home with two broken arms when
5 you live alone, but she was an insured person, and
6 technically speaking, you know, she didn't have a
7 reason to be hospitalized. So, they sent her our. We
8 of course, would have kept her. We would have said,
9 Well, this is what we do. You know, you're an
10 elderly person. You have two broken arms. How could
11 you possibly get yourself to the toilet or food? We
12 were able to—to bring her into one of our long-term
13 care facilities. So there's just no understanding
14 that your—your family structure, your housing
15 structure whether you can get food, whether there are
16 people from insurance point of view if pneumonia is
17 three days, three days of payment. You keep them five
18 days, you should, that's your problem.
19 CHAIRPERSON RIVERA: So, is it homecare?
20 Is that—is that--?
21 DR. THEODORE LONG: Well, it's—it isn't
22 even as simple as homecare because often people don't
23 have circumstances that you can care for them at
24 home or four hours means nothing if you have two
25 broken arms. No, it's more recognizing that certain

2 people can't be sent home or conversely certain
3 people can't be cared for at home. Wat all our
4 hospitals, Mr. Nunez is a wonderful Administrator for
5 Lincoln and I recently worked on somebody where the
6 family had just brought the person because they
7 couldn't care for them any longer, right and people
8 bring them to public hospitals. I'm sorry we can't
9 take care of him. He requires too much care. The
10 insurance company says but there's no—there's no
11 reason for admission. We say, well, but what are we
12 going to do? We're going to put this person out on
13 the street? No. So we do it out of mission. Other
14 hospitals simply say well that's how it is, but not
15 us.
16 CHAIRPERSON RIVERA: And I appreciate
17 that about Health and Hospitals. I really do that
18 you will truly take care of everyone. So, I know that
19 we have committee members with questions. So I want
20 to give them an opportunity and thank you for—
21 MARIELLE KRESS: Thank you.
22 DR. THEODORE LONG: And to you--
23 CHAIRPERSON RIVERA: --answering as much
24 as you could.
25

2 CHAIRPERSON LEVINE: Thank you, Madam
3 Chair. I think that Council Member Cohen has a
4 question.
5 COUNCIL MEMBER COHEN: Thank you, Chairs.
6 Dr. Katz, nice to meet you face to face. I know we've
7 spoken on the phone--
8 DR. THEODORE LONG: Yes.
9 COUNCIL MEMBER COHEN: --and I know that
10 you know that NCBs in my district--I see Christina
11 here and, you know, we really, you know, the Speaker
12 has been supportive. Every time I've gone to the
13 Speaker and said I want to help and NCB he's always
14 been there and—and I expect that to continue. So, I
15 think that you know that if, you know, you need my
16 support, it's always there.
17 DR. THEODORE LONG: Thank you.
18 COUNCIL MEMBER COHEN: You know, I guess
19 and I was the Chair of the Mental Health Committee
20 last term, but I have not been, you know, and I'm new
21 to the Health Committee now. So, first, I just want
22 to say, you know, I was very concerned about the—the
23 structural deficits at Health and Hospitals, and I'm—
24 I'm sort of really sort of staggered to say well, we
25 decided to bill insurance, and we're—that's making us

2 financially viable like can you—can you expand on
3 that a little bit about just what was going on, and
4 you know--
5 DR. THEODORE LONG: Sure, well--
6 COUNCIL MEMBER COHEN: --and what's
7 changed or…?
8 DR. THEODORE LONG: I mean I wasn't here,
9 but this would be my understanding. Prior to the ACA,
10 poor people did not have insurance unless they had a
11 disability. So that was this small group of people.
12 So large numbers in a place like New York City of
13 low-income people without insurance. The ACA comes
14 along, and the federal government says we're giving
15 people insurance now, and so we're going to cut the
16 subsidies to public hospitals because you don't need
17 as much money because you're going to have all of
18 these people who have insurance. But because the
19 culture of Health and Hospitals was always well, we
20 provide care for free, nobody really turned on the
21 mechanism. I the case and my—my great Public Health
22 colleague, Public Health did a great job of enrolling
23 people in communities to get insurance, but if there
24 were already going to a wonderful place like NCB
25 nobody felt they had any need. They went to ENC, they

2 got great care, the care was free. No one—no one
3 articulated-the-the patient didn't articulate they
4 needed insurance and the system didn't articulate
5 that they needed insurance. So, we—we weren't
6 enrolling the people who could have been enrolled and
7 who could have paid, and then we never had the
8 infrastructure to bill, and as I was alluding to, and
9 I'm very open, some insurance companies have
10 incredibly predatory practices. You know, you, the
11 patient needs care, but you didn't call them, you
12 know, and hour before. Disallowed. You didn't fill
13 out this form. Disallowed. You—you didn't get the
14 bill to us soon enough. Disallowed and Health and
15 Hospitals just lived that life, and so once we said
16 no in order to fulfill our mission, we don't money
17 from people, but we want the money from the
18 insurance. It did turn out to be a rather large
19 amount of money and there was necessary
20 administrative costs that went along with it. So, it
21 wasn't alright. It was saying: Fewer cars, fewer
22 space, fewer administrators put all our money into
23 nurses, doctors, pharmacists.
24 COUNCIL MEMBER COHEN: Yeah, I—I don't
25 mean—my wife is a physician and I hear her appealing

2 the denials all the time as she's dictating. Yeah,
3 could you just—I don't know if there's somebody who
4 is uninsurable in New York City and what those—who
5 those people are, an what is their experience it they
6 had a—if they have cancer, what is their—what is
7 their course or what happens to them?
8 DR. THEODORE LONG: So, there are
9 probably about 300,000 people in New York City who
10 are uninsurable because they don't have documents
11 that would get them Medicaid. Um, plus some who are
12 insurable, but—but the co-pays are unaffordable to
13 them. So, what would happen is they—they would go to
14 a Health and Hospital facility. If they in an
15 emergency all hospitals under the EMATALA Laws, which
16 your wife would know all about have to be seen
17 through an emergency room, but cancer is one of the
18 examples where there's a huge hole because you don't
19 need to be seen in an emergency room. You need your
20 Chemotherapy, but there is no way to pay for that
21 Chemotherapy, and so all of those people would get
22 care. Unfortunately, we have several places that are
23 centers of excellence for the care of people with
24 cancer at Health and Hospitals.
25

2 COUNCIL MEMBER COHEN: But within the
3 system?
4 DR. THEODORE LONG: Yes, they would—
5 they'd have to within the system.
6 COUNCIL MEMBER COHEN: Thank you. That's
7 good to know. Thank you very much Chairs.
8 CHAIRPERSON LEVINE: Thank you, Council
9 Member Cohen, and I believe Council Member Holden has
10 a question.
11 COUNCIL MEMBER HOLDEN: Thank you, Doctor
12 for your testimony and you mentioned something
13 earlier about that gentleman who couldn't afford the
14 co-pay for his inhaler. Is that a regular occurrence
15 that you're seeing, and how do you learn about that?
16 With follow-up or calls to the individual?
17 DR. THEODORE LONG: Well, in his care
18 because I was—I was his—he came to me as a doctor at
19 my practice at Governeur, but yes, we hear about it
20 all of the time, and-and frankly there were even
21 blogs on the Internet of people all over this country
22 who are insured and cannot pay for their medications
23 because the—the medication is covered, but what it
24 covered means $60 and you're a day laborer.
25

2 COUNCIL MEMBER HOLDEN: So, what do you
3 do in that case? So, let's say somebody—you—you do a
4 follow-up call right?
5 DR. THEODORE LONG: But, so what I—I mean
6 what I did is I got him the medicine, but I could do
7 that because of Health and Hospitals.
8 COUNCIL MEMBER HOLDEN: But it was—so but
9 is—that—that seems, I mean I even did that because
10 the co-pay was ridiculous and I said I'm not going to
11 take this. I mean, you know, so it's like you don't—
12 you don't— I mean it's really self-defeating, though
13 when you go to see a doctor, they recommend or they
14 prescribe this and that, and it's the cost, and so I
15 think if—if we have something built in that we could
16 actually fix that. What do you—what are some
17 suggestions you have.
18 DR. THEODORE LONG: So, um, the big thing
19 we're doing is we is we're establishing retail
20 pharmacies at all our facilities. So, previously
21 Health and Hospitals provided—had pharmacies for
22 people who were uninsured, but we didn't accept
23 people who were ensured, which was not a smart
24 business decision on our part, and it also makes it
25 impossible to solve for the is person because the

2 person who had the $60, I'll get enough form his
3 insurance to cover my cost on the medication. So,
4 I'll be able to give him his medication. I won't lose
5 money. I won't lose any of the city's subsidy meant
6 for the uninsured. He'll get his medicine, but to do
7 that I need retail pharmacy because I have to be able
8 to bill his insurance for the part that they will pay
9 and Health and Hospitals for unclear reasons gave up
10 all of its retail pharmacy ability about ten years
11 ago, and now we're re-establishing that in all our
12 clinics.
13 COUNCIL MEMBER HOLDEN: Oh, good, great.
14 thank you. Just one other question to follow up on
15 Council Member Rivera's question about the annual
16 average cost for uninsured patients. You said you
17 could figure that out now. You can actually cone up
18 with an estimate? How long would that take to get
19 those numbers?
20 DR. THEODORE LONG: Well, it's that I'll
21 go back now and look at—well first, I think to it
22 truly I think we have to live in Brooklyn. So, that's
23 December, and starting therefore in January, we would
24 have our entire system, and I would be able to take
25

2 out. So, you know, I think that's information that
3 we could certainly work on for February and March.
4 COUNCIL MEMBER HOLDEN: February and
5 March. Okay. thank you. Thanks. Thanks, Chairs.
6 CHAIRPERSON LEVINE: Thank you so much,
7 Council Member Holden and thank you Dr. Katz and the
8 entire panel.
9 DR. MITCHELL KATZ: Thank you, thank you.
10 CHAIRPERSON LEVINE: And I would like to
11 call up now our next panel, which includes Helen
12 Schaub from 1199 SEIU; Valerie—also Valerie Gofay
13 (sp?)—sorry for the mispronunciation at 1199; Judith
14 Cutchin from New York State Nurses Association; Rose
15 Duchan from Chacanis (sp?) and Sonya Lawrence.
16 Sorry. This is also a nice new person, Sonya
17 Lawrence from Lincoln Hospital, and I know that
18 because Helen is on a very, very short time table if
19 it's okay with the rest of the panel, we'll have
20 Helen kick us off.
21 HELEN SCHAUB: Alright. So, I'm—I'm—
22 we're going to actually do this together, and because
23 that's part of what we want to demonstrate is all
24 pieces of this supporting this idea. So, then we'll
25 make room because I know there's one—one a couple of

2 fewer seats. So, you've heard a lot of the
3 statistics. I think that we're in this in our
4 testimony and just let me introduce ourselves first
5 and then I'll—we're going to be super quick. So my
6 name is Helen Schaub. I' the Policy and Legislative
7 Director for 1199.

8 VALERIE GOSS: Hi. I'm Valerie Goss. I'm
9 an employee for H&H and a delegate from 1199.

10 LORI ANN ZAY: My name is Lori Ann Zay. I
11 work at the Community Health Center of Richmond in
12 Staten Island

13 HELEN SCHAUB: So, I think the broader
14 point I mean everybody obviously in their earlier
15 testimony talked about the need, the ways in which in
16 order to truly provide universal healthcare access
17 and to reduce avoidable hospitalizations especially
18 at H&H, which sees so many of the uninsured in the
19 Acute Care side that we really need this legislation,
20 which expands the good work that NYC Cares is doing
21 to the broadest range of trusted community providers.
22 So, basically, we're here to support this
23 legislation, and I think we wanted to do it together
24 because we really as a labor union that represents
25 workers in H&H and in the clinics in H&H and in the

2 emergency rooms like where Valerie works, as well as
3 workers in FQHCs throughout the city. I think we
4 really have a perspective that shows the quality care
5 that's delivered in all of those contexts, and the
6 ways in which all of those providers including the
7 frontline workers are necessary to truly provide
8 quality access for all of our residents throughout
9 the city. So, we're here in support of this
10 legislation. We really want to thank both chairs as
11 well as the Speaker for introducing it and moving it,
12 and I just want to have Valerie and Linda say a
13 couple of words about the work that they do, and
14 their perspective from where they sit.

15 VALERIE GOSS: Okay as I said, I'm an
16 Emergency Room Licensed Practical Nurse. I literally
17 hear the cries of—in the community that I work it's
18 immigrated population, heavy population and these
19 people they cry. They—when they won't—when they will
20 not talk to the doctors or their administrators ,
21 they cry on us. They tell us, you know, they're
22 afraid, they're—You know, we hear their pain. I mean
23 we all sit around and hear talk about statistics and
24 numbers, but this preventative express care service
25 is badly needed. We used to have clinics all over

the places where people did feel comfortable to go to. So, now what's happening is the emergency room is being over-populated. The staff is being stressed and the care is not really going to be rendered because people are trying to—trying to satisfy the Administration and get the job done, and who are hurting is the patients that's feeling the pain.

LORI ANN ZAY: Hi, I work at the front desk at the Community Health Center of Richmond and in Staten Island and unfortunately we do not have a hospital that is an HHC. There are very few and far places that people can go. Where I work is in Port Richmond, which is a heavily undocumented area. We do have a lot of people that are scared, but we do have a lot of people that do come in and they feel like it is a community. A lot of people it's nice to see when they bring their children who are insured that there are parents who are taking care of themselves even though they are undocumented and they are coming in for the care. So, we are taking care of the whole entire family.

CHAIRPERSON LEVINE: Thank you for that. Okay.

2 HELEN SCHAUB: So, just in closing and
3 know we have a lot of advocates who are here in
4 support of this legislation, but again, we want to
5 support it. We think it's the right step to expand
6 H—to expand NYC Cares to be fully comprehensive. We
7 also just want to say a brief word in support of the
8 Resolution--
9 CHAIRPERSON LEVINE: [interposing] If you
10 can just turn that mic on because we're not picking
11 you up.
12 HELEN SCHAUB: [on mic] Yes, we want to
13 say a brief word in support of the resolution.
14 We've—you know, our union in our constitution says
15 that we're for universal healthcare. We fought for
16 that in the trenches on the doors in many different
17 ways for a long time and, you know, anything that
18 Albany can do we're up there trying to make sure that
19 they can invest the resources that are necessary to
20 provide access for the folks that do not have it. So,
21 thank you very much for having us, and we'll—we'll
22 make some room.
23 CHAIRPERSON LEVINE: Thank you so much
24 for speaking and for your work on this important,
25 important sector. Please Judith.

2 JUDITH CUTCHIN: Hello everyone. Okay,
3 Hi. My name is Judith Cutchin. I am a nurse at
4 Woodhull Hospital for the last 28 years in Brooklyn,
5 one of the eleven of the wonderful public hospital
6 system. I am also on the Board of the Directors for
7 the New York State Nurse Association, and the
8 Executive Council President that represents the
9 Public Health System Nurses, 8,500 of those nurses,
10 wonderful hard working nurses. I thank you for the
11 opportunity for allowing me to speak and on behalf of
12 my NYSNA, we thank Councilman Levine and Councilwoman
13 Carlina Rivera for their support. I'm here today to
14 express in strongest terms our support for immigrants
15 especially those whose status under federal law makes
16 them ineligible for financial participation. This
17 onslaught against our immigrants on the federal level
18 has to stop, and it does here in New York City
19 including in all public hospitals, which remain open
20 to all regardless of their ability to pay or their
21 immigration status. The City Council has displayed
22 outstanding leadership in support of both the public
23 hospitals and our city's diverse populations
24 including undocumented immigrants. The New York Care
25 Program offers the promise of quality care to 600,000

2 uninsured New Yorkers including undocumented
3 immigrants. In spite of threats from Washington to
4 limit Medicaid and other federal assistance to safety
5 net hospitals, we here in New York must have enough
6 resources to guarantee quality care under the New
7 York Care program. Otherwise, two-tiered healthcare
8 systems in our city will prevail and with the
9 addition of 600,000 new patients struggle even more.
10 New York City Care offers the promise of extensive
11 primary and acute care. One in place, it holds
12 promise of rapidly close to tier-tired systems and
13 for undocumented immigrants it is—it means a decent
14 life here knowing that quality healthcare is within
15 their reach. I am here today to ask you to
16 understand that we cannot keep up with new demands on
17 public hospital care without funding for enough
18 nurses and other frontline staff caregivers to do the
19 job. Since 2014, the number of nurses in New York
20 City H&H system has declined by 685 or more than 8%.
21 This while acute staph (sic) is more serious as the
22 illness increased 14%. New York City Care hast got
23 off to a good start in the Bronx where half the
24 target of the 10,000 new patients were accomplished.
25 These factors in the public hospital, less nurses,

2 sicker patients, a new program, New York City Care
3 adding more patients while this cannot be sustained.
4 We believe that $120 million should be appropriate—
5 appropriated by the Council to be specifically
6 dedicated to hiring 1,000 nurses and other
7 caregivers. The others are patient care techs.
8 Nurses they the LPNs and other direct care providers
9 and staff. This additional workforce can go a long
10 way to meeting the healthcare demands of the public
11 system and New York City Cares, adding patients
12 including undocumented immigrants. They like all New
13 Yorkers deserve quality care. I, too, am a lifelong
14 New York City Health and Hospital patient. I was
15 born in health—in New York City Healthcare in Kings
16 County and I've been a patient ever since. I won't
17 tell you my age, and we support the-the 1658 to
18 expand New York City Care to FQHCs making—and make
19 the private hospitals provide the same care if they
20 get enough funding, and we also support Resolution
21 918 to expand the care to include the undocumented,
22 our most vulnerable patients. Thank you. [background
23 comments/pause]
24 SONYA LAWRENCE: Good afternoon. My name
25 is Sonia Lawrence, and I'm a nurse at the Lincoln

2 Hospital in the Bronx part of the New York City
3 Health and Hospital system. Lincoln is located in the
4 South Bronx in a community with a large population of
5 undocumented immigrants. It is an area with many
6 challenges, a few blocks from the 145th Street Bridge
7 with Interstate 87 intersecting the neighborhood,
8 dotting with depots of garbage and other diesel
9 trucks. The asthma and other lung ailments alone
10 would keep us busy. We are proud to provide to
11 quality care to immigrants and to all our patients no
12 matter their ability to pay or immigration status.
13 New York Care launched and enrolled goal of 1,000 in
14 the Bronx on August 1st and has already met more than
15 half the goal. That is very good, but as more people
16 enter our public system for care, we have to have
17 enough nurses and other caregivers to do our jobs.
18 Our emergency room treats more persons than any other
19 city system. We understand the hardship of
20 providing care in this setting. Still, we experience
21 great satisfaction in treating patients include
22 undocumented immigrants. I speak for my fellow
23 nurses at Lincoln Hospital in saying that a realistic
24 budget allocation is needed meet the additional
25

2 demands already entering our system by way of New

3 York Care. Thank you.

4 CHAIRPERSON LEVINE: Thank you very much,

5 Nurse Lawrence and Nurse Cutchin and-and Nurse

6 Cutchin, we're not going to ask what year you were

7 born. We know it was in the 1980s.

8 SONYA LAWRENCE: Well, I could be 50.

9 [laughs]

10 CHAIRPERSON LEVINE: And thank to NYSA,

11 which has just been so key in this fight, and every

12 healthcare fight, and Rose, you can take it away.

13 ROSE DUHAN: Okay. Good afternoon. Thank

14 you for the opportunity to provide testimony in favor

15 or Intro 1668. My name is Rose Duhan and I'm the CEO

16 of the Community Healthcare Association of New York

17 State, the primary care association for federally

18 qualified health vendors. I want to thank Council

19 Member and Chair Levine for reminding us of the

20 Community Health Center History because it really is

21 about ensuring access to underserved communities in

22 their communities for people who would otherwise not

23 have care. CHCANYS is is the voice of Community

24 Health Centers that serve as leading providers of

25 primary care in New York State. We work closely with

2 more 70 Federally Qualified Health Centers also known
3 as Community Health Centers that operate over 800
4 sites statewide, and as has been mentioned, 500 sites
5 here in New York City. FQHCs are non-profit,
6 community run clinics located in medically
7 underserved areas that provide high quality, cost-
8 effective primary care including behavioral health
9 services and oral health services and dental care is
10 especially difficult to access for so many people who
11 do not have insurance, and even people who do have
12 insurance often do not have dental care. So,
13 ensuring that access is so important, but the mouth
14 is part of the body and needs to have medical care
15 just like the rest of the body. All health vendors
16 are required to have a sliding fee scale for patients
17 under 200% of the Federal Poverty Limit. Federal Law
18 also mandates that a majority of heath center board
19 members be patients of that health center ensuring
20 that the center is reflective of and responsive to
21 their community. So it is the communities—the
22 community members that govern the Community Health
23 Centers to ensure that the services, and the way that
24 they are delivered reflect the community. The 500
25 Community Health Center sites in New York City

2 scattered throughout all five boroughs, and in nearly
3 every community district create an expansive primary
4 care safety net. 1.4 million or 1 in 7 New York City
5 residents receive care at a Community Health Center.
6 Health Centers are experts at providing care to those
7 most in need. More than 90% of Health Center patients
8 in New York are below 200% of federal poverty limit;
9 62% receive Medicaid and 15%--16% are uninsured,
10 which is three times the statewide rate of 5%
11 uninsured. Last year, New York Health Centers serve
12 220,000 uninsured New Yorkers, approximately one-
13 third of all uninsured residents. Community Health
14 Centers are more than just a doctor’s office. They
15 provide a full range of culturally appropriate
16 comprehensive health and support services including
17 physical health, behavioral health and as I said,
18 dental services. In addition, they provide enabling
19 services such as arranging for transportation, case
20 management, insurance enrollment assistance and
21 health education . While all health centers are
22 required to provide are to anyone seeking it, some
23 health centers have special expertise in serving
24 certain populations like people experiencing
25 homelessness, migrant agricultural workers, refugees,

2 and people from the LGBTQI community health centers
3 also operate approximately 125 school-based health
4 centers in New York City. . CHCANYS is pleased to
5 support Intro 1668 , which would create a health
6 access program in New York City aimed at bringing the
7 over 600,000 uninsured New Yorkers into care. Under
8 that program enrollees would be offered a medical
9 home providing comprehensive primary care in their
10 community district, and a patient navigator to assist
11 them in access services. . CHCANYS is in support of
12 the recently implemented New York City Care, and I
13 want to thank our partners at H&H, and that has
14 proved to be an important root to access especially
15 for specialty care for FQHC patients because
16 Community Health Centers do not provide a lot of
17 specialty care. I would be remiss if I did not
18 mention that Gotham Health, a federally qualified
19 health center and member of CHCANYS is a critical
20 component of the expansive network of New York City
21 health centers, providing comprehensive primary care
22 services to hundreds of thousands of New Yorkers
23 every year. We work closely with Health and
24 Hospitals and Gotham leadership to have this pre—and
25 appreciate the transparency and open communication

2 and lipstickings (sic) and the other New York City
3 Health Centers as New York City Care has gotten
4 underway. So, thank you. CHCANYS urges the City
5 Council to work with the Administration to build on
6 the early successes of the New York City Care program
7 by leveraging the breadth and expertise of the 500
8 Community Health Center sites throughout the city.
9 All Health Centers share a common mandate, to provide
10 high quality, comprehensive primary care services to
11 anyone seeking care regardless of insurance coverage,
12 income or immigration status. CHCANYS is appreciative
13 of Intro 1668's effort to design a health access
14 program, and appropriates all of New York State—New
15 York City's Community Health Centers, . CHCANYS
16 looks forward to working with the Council and the
17 Administration to ensure that Intro 1668 utilizes and
18 embraces the city's strong primary care safety net.
19 We wholeheartedly support enhancing access to care
20 throughout New York City by leveraging the full
21 complement of Community Health Centers in all five
22 boroughs. . CHCANYS supports Intro 1668 and urges
23 the Council and the Administration to design a health
24 access program that supplements an existing state and
25 federal Community Health Center funding, aligns with

2 federal sliding fee scale requirement at Community
3 Health Centers and supports the Health Center mandate
4 to provide care to anyone who seeks it. Thank you
5 for the opportunity to speak. I'm happy to answer any
6 questions.
7 CHAIRPERSON LEVINE: Thank you very much,
8 Rose. I just want to remark on one more way that Dr.
9 Katz is exceptional is that he's still here at the
10 hearing, and it's very unusual for commissioners to
11 remain after they're done speaking themselves, and we
12 appreciate that. It means a lot because the
13 perspective that we're hearing here is very, very
14 important. Can you clarify, Rose, how many Community
15 Health Centers are there, FQHCs in the five boroughs
16 of New York City?
17 ROSE DUHAN: These 500 sites--
18 CHAIRPERSON LEVINE: Yes.
19 ROSE DUHAN: --that Community Health
20 Centers operate that's about—I want to say about 40
21 organizations, different organizations that—that are
22 located in the city.
23 CHAIRPERSON LEVINE: That's quite large
24 network, and forgive if you said this, how many
25 patients a year does this network serve?

2 ROSE DUHAN: 1.4 million in New York
3 City.
4 CHAIRPERSON LEVINE: How many?
5 ROSE DUHAN: 1.4 million last year that
6 we served in New York City.
7 CHAIRPERSON LEVINE: That-that—that
8 probably is larger than any other institution. IO
9 mean I think it's even more than—that Health and
10 Hospitals.
11 ROSE DUHAN: That does—that does
12 incorporate all of the Gotham Health Centers.
13 CHAIRPERSON LEVINE: Oh, got it.
14 ROSE DUHAN: So, yes. [laughs]
15 CHAIRPERSON LEVINE: But we're—we're
16 double counting a little bit.
17 ROSE DUHAN: Yes, but there are hundreds—
18 hundreds of thousands that are seen at Gotham Health,
19 and then on top of that, all the other health centers
20 also provide another—why did I say that? Let's see.
21 [laughs] It's excellent and professional.
22 CHAIRPERSON LEVINE: Several of your
23 members took part in the Action Health NYC Pilot
24 correct?
25 ROSE DUHAN: Correct.

2 CHAIRPERSON LEVINE: I think it might
3 have been—what was it? 10, 11 sites.
4 ROSE DUHAN: Yes, it was a pilot.
5 CHAIRPERSON LEVINE: Great. Can you
6 reflect on the experience and the success of that
7 pilot from the perspective of the Community Health
8 Centers?
9 ROSE DUHAN: Um, I think the Community
10 Health Centers appreciated the opportunity to
11 participate, and to, um, expand access to care for
12 patients.
13 CHAIRPERSON LEVINE: Okay, well, we
14 certainly concur. Okay. Thank you, Rose. Thank you
15 to the organizations you represent for what you're
16 doing for healthcare on the ground in communities for
17 1.4 million people including Gotham Health.
18 ROSE DUHAN: Thank you.
19 CHAIRPERSON LEVINE: I resonate with
20 that. (sic)
21 ROSE DUHAN: Thank you the Council.
22 CHAIRPERSON LEVINE: Okay, our next panel
23 includes if you have been able to stay. I hope he
24 has, Dr. Juan Tapia from Somos Community Care; Arlene
25 Cruz from Make the Road; Max Handler from New York

2 Immigration Coalition. I believe this is also from—
3 yes, from Planned Parenthood Miriam Mohamed Miller;
4 Natalie Entariano from Care for the Homeless; and
5 Juan Pinzon from the Community Service Society.
6 Folks and one more if we can fit—fit her in Paloma
7 Izquierdo. This is an all star panel if ever there
8 was one. [background comments/pause]
9 CHAIRPERSON LEVINE: Doctor, do you want
10 to kick us off?
11 DR. JUAN TAPIA: Yes,
12 CHAIRPERSON LEVINE: Thank you.
13 DR. JUAN TAPIA: Thank you. Good
14 afternoon. I want to take this moment to thank the
15 New York City Council Speaker Corey Johnson,
16 Community and Health Chair Council Member Mark
17 Levine, the Committee on Hospitals, Chairs
18 Councilwoman Carlina Rivera, and all of the Council
19 Members that are here with us today. My name is Dr.
20 Juan Tapia, and I am a physician in the Somos
21 Network. I want to start by mentioning one of the
22 speakers that mentioned that nowadays there are many
23 patients that go to the hospitals that are vaccinated
24 and we are seeing less of the infectious diseases
25 that were once prevalent in the '80s, and that has to

2 do with a lot of with administration, but it has to
3 do also a lot with the primary care physicians. At
4 Somos we are more than 2,500 family doctors treating
5 over 700,000 patients in traditionally under-served
6 counties in the Bronx, Long Island, Queens and
7 certain pockets of Manhattan. I want to applaud the
8 New York City Council for introducing bright
9 groundbreaking legislation that will bring high
10 quality to ensure New Yorkers. At Somos like myself
11 most of our doctors speak to our patients in their
12 language, but their language is not Spanish or
13 Chinese. We speak in the language of empathy. We
14 have American doctors that speak no English to
15 Hispanic patients that do not understand English, but
16 they know exactly what the doctor is saying, and this
17 is through empathy by knowing the community. We have
18 doctors that are practicing where other doctors don’t
19 want to—to be. I’ve been in practice in Washington
20 Heights and in the South Bronx for more than 30 years
21 when a lot of the hospitals used to send patients to
22 the streets, newborn mothers to find providers on
23 their own. And, I was also here with Medicaid used
24 to pay $8.00 for visits, and I was also here when
25 they came up with a program for providers for new—new

graduates that were paid around $40 per visit, and that was followed by managed care, and today I am glad and I hope that this program continues, which is the program that pays physicians for keeping the patients well, and not for doing procedures or seeing a hundred patients a day. That the main criteria is how well are you keeping the patients? And we agreed for a law that requires a medical home and at least one acute care hospital to with specialists in each borough. The primary care providers are surviving due to the efforts of lawmakers that are making payments based on the high quality of care that we provide. We are now providing access to culturally competent care and empathy in many languages, and I want to state that primary care providers were here way before Christopher Columbus because even though they didn't have modern medicine, they had the most important thing in medicine, which is empathy and the ability—the ability to listen to patients and also always working with our most vulnerable population. I thank you all. Thank you for this opportunity.

CHAIRPERSON LEVINE: Thank you, Dr. Tapia. Thank you. Next.

2 MAX HADLER: Good afternoon everyone. My
3 name is Max Hadler. I'm the Director of Health Policy
4 at the New York Immigration Coalition. I want to
5 thank the Chairs Levine and Rivera for calling this
6 hearing. I first want to address NYC Care in its
7 current form. From the beginning at the NYC we've
8 supported NYC Care. We think sends a really powerful
9 message of inclusion to immigrant communities that
10 are under constant attack from Washington and the
11 care, coordination and customer service mechanisms
12 that we think meaningfully improve care for uninsured
13 New Yorkers half of whom are undocumented. We think
14 the NYC Care team at Health and Hospitals has done an
15 admirable job getting the word out about the program
16 along with community-based organizations like
17 [speaking foreign language] and we're also encouraged
18 by the extended pharmacy hours that have yielded
19 higher than expected utilization in the program's
20 first few months. At the same time we remain
21 concerned about the pace of NYC Care's methodical
22 rollout across the remaining four boroughs and the
23 $100 million promised investment, which we have said
24 from the beginning that we think is insufficient. So,
25 in the meantime we urge Health and Hospitals and the

2 Council in an oversight role to ensure that data are
3 regularly made public on important program parameters
4 as it ramps up. So, this would include program
5 spending details, total enrollment by age, gender,
6 preferred language and geography information on
7 clients deciding not to enroll in coverage or in NYC
8 Care because of public charge concerns or other
9 immigration related fears. Indications that the
10 collaborative care model is actually needing to
11 increase access to behavioral health services, and
12 also the volume and types of calls into the customer
13 service line. We also have from the beginning
14 expressed reservations about limiting a new citywide
15 access to care program only to Health and Hospitals.
16 The Acton Health NYC pilot clearly demonstrated that
17 improving linkages to community health centers—
18 between community health centers and Health and
19 Hospitals has to be a priority in improving access to
20 care for uninsured New Yorkers across all types of
21 care that they need. Intro 1668 provides a framework
22 for doing that, and we thank Council Members Levine
23 and Rivera for launching this important effort. We
24 think that Intro 1668 should build on the existing
25 structure of NYC Care, and also any funding to

2 implement the provisions of Intro 1668 be in addition
3 to the at least $100 million that have already been
4 allocated or promised to the NYC Care program in its
5 current form. The expansions described in the bill
6 can't be achieved with the existing funding. We urge
7 the Administration and the Council to work together
8 to make this a financial reality because it's really
9 hard to imaging that a successful effort to guarantee
10 comprehensive health access in New York City cannot
11 improve providers—cannot include providers beyond
12 Health and Hospitals, and finally, we
13 enthusiastically endorse resolution 918. We thank
14 Council Member Adams and the Women's Caucus and
15 Committee Chair Levine for bringing it up for
16 consideration. The NYC is one of the co-leads of the
17 Coverage for All Campaign. We have been working for
18 years to get a state funded essential plan
19 introduced. We thank Senator Brieda (sp?) and
20 Assembly Member Gottfried for leading the effort on
21 that. As one of the leads of this campaign, we
22 greatly appreciate the Council's consideration of the
23 resolution, and we strongly urge its passage as a
24 public and official declaration of the Council's
25 willingness to stand up for affordable healthcare for

2 all, and I just want to say that while Governor Cuomo
3 and other state leaders sit on their hands as
4 hundreds of thousands of people continue to go
5 without health insurance, it' gratifying to see the
6 city, both the Council and the Administration take
7 action to improve access to care for immigrant New
8 Yorkers to contemplate how we can continue to improve
9 upon the programs that we already have. We
10 appreciate your efforts and we look forward to
11 continuing to work with all of you until all New
12 Yorkers have access to timely affordable high quality
13 care. Thanks a lot.
14 CHAIRPERSON LEVINE: Thank you Max. In a
15 time when immigrants in the city are justifiably
16 scared because we have a mad man in the White House,
17 how are we going to overcome the obstacle of—of—of
18 people who are fearful to participate in any
19 government program even a city government program?
20 MAX HADLER: I think one of the
21 approaches is that lots of organizations are taking
22 what actually is already happening through NYC Care
23 is that community-based organizations are being
24 funded to provide information and to do outreach.
25 They're already a trusted source, and I think the

2 broader message of creating universal programs is
3 also very, very important. There may be hesitation
4 overall because of public charge or because of other
5 administrative attacks on immigrant communities, but
6 creating a message that all of New York City and
7 ideally all of New York State except is failing to
8 act on it is open to care and open to coverage for
9 everyone. It sends an incredibly powerful message
10 that functions as a bulwark against the federal
11 government. You are not going to persuade everyone
12 who reasonably has fears about programs to enroll
13 necessarily, but I think that there's already been a
14 demonstration that we're mitigating the chilling
15 effect of these administrative attacks through all
16 the community outreach and education and training
17 that we're doing, and I think the—the best thing that
18 we can do to counteract it is to continue to create
19 programs and to promote programs that are open to
20 everyone.
21 CHAIRPERSON LEVINE: Amen to that.
22 Arlene.
23 ARLENE CRUZ: Good afternoon. Well, good
24 afternoon. So, my name is Arlene Cruz and I'm a
25 Health Programs Manager at Make the Road New York.

2 Thank you for giving us this opportunity today to
3 provide testimony on the essential plan expansions
4 through Coverage for All and NYC Care bill. Make the
5 Road fully supports the City Council's resolution in
6 support of coverage for all's bill A-5974 and S-3900
7 to create a state funded essential plan for all and
8 New Yorkers to 200% of the Federal Poverty level
9 regardless of their immigration status. Every year
10 Make the Road serves hundreds of uninsured New
11 Yorkers who are anxiously awaiting the opportunity to
12 be able to enroll into health insurance since they
13 are currently not eligible due to their immigration
14 status, and even without access to health insurance,
15 they understand the cost and life saving implications
16 for access to care. Yet, health insurance
17 discrimination based on immigration status affects
18 more than 400,000 New Yorkers. Take for instance
19 Antonio, a Make the Road member a Bushwick resident
20 for over 20 years diagnosed with kidney failure. He
21 received daily—he received dialysis at his local
22 hospital, but he doesn't qualify for a kidney
23 transplant because he's undocumented and uninsured.
24 Due to his condition he has a very limited income and
25 is usually exhausted after-after his treatments,

2 which he receives three to four times a week. Since
3 he is completely depleted and has faced week long
4 hospitalizations due secondary effects. He doesn't
5 have health insurance with the cost of seeing his
6 primary care doctor or prescription medication, which
7 he needs on a consistent basis. To be on so little
8 medical, the city must [Speaking Spanish] If I had
9 health insurance it would be easier for me, less
10 expensive, and it would-and it could save my life he
11 said. The state's healthcare providers already spend
12 nearly $130 million a year on uncomplicated care for
13 uninsured people. Coverage for All process—proposes
14 to create a state funded essential plan, which would
15 help alleviate those costs. The essential plan, a
16 popular federal program has proven to be successful
17 in New York and already has almost 800,000 enrollees.
18 Additionally because the essential plan is not part
19 of the new Public Charge Rule, it wouldn't be
20 impacted and even if the horrific new rule goes into
21 effect. Already a function—a functioning mechanism,
22 the essential plan should serve as an ideal health
23 program model to replicate at the state level to
24 cover immigrants not eligible for health insurance
25 because of their status Make the Road also supports

2 NYC Care programs since its inception. We are one of
3 the CBOs participating in the Immigrant Health Task
4 Force in 2014 that helps create the pilot, Action
5 Health Projects several years ago and even
6 coordinated a member based focus group to provide
7 feedback prior to launching the program. We are
8 excited with the launch of the New York City Care
9 Program in the Bronx and anticipate its expansion
10 into the other boroughs with its added benefits such
11 as appointment availabilities and extended hotline
12 and pharmacy hours, essential services that our
13 community has long advocated for. It is evident that
14 the NYC Care program is transforming in a direction
15 that matches our communities' current needs and it's
16 precisely because of those reasons that we support
17 the funding for CBOs to conduct outreach efforts for
18 NYC Care. We ask that you ensure continued funding
19 for CBOs' involvement in this work, and not just for
20 a temp funding. As you all know, CBOs are highly
21 valued to our communities and play a vital role in
22 the program's success. Furthermore, we support the
23 addition of the FQHCs into the program. However, we
24 want to enhance the program that particularly
25 benefits from it and not take away benefits from our

2 communities. Lastly, to the Council Members here and
3 NYC for taking care actions to support access to care
4 for immigrant New Yorkers through both the essential
5 plan expansion and the NYC Care bills. Thank you.
6 CHAIRPERSON LEVINE: Thank you so much,
7 and Maryam, please.
8 MARYAM MOHAMMED: Good afternoon. Thank
9 you Council Members Levine and Rivera for holding
10 this hearing and Corey—Council Speaker Corey Johnson.
11 My name is Maryam Mohammed and I am the Government
12 Relations Associate at Planned Parenthood of New York
13 City. PPNYC is the trusted health provider of sexual
14 and reproductive health services in New York City for
15 over a hundred years. Thank you so much for the
16 opportunity to testify. PPNYC proudly supports
17 Resolution 918 which calls on the enactment of the
18 State Senate Essential Plan to allow access to all
19 New Yorkers regardless of immigration status.
20 Presently, many New Yorkers are barred from obtaining
21 public coverage through the New York State
22 Marketplace because of their immigration status,
23 leaving over 400,000 individuals in the state with
24 limited access to care. Expanded access to the
25 essential plan could allow for an additional 100,000

2 individuals to enroll in affordable coverage. As a
3 trusted healthcare provider, we witness the
4 challenges and barriers immigrant New Yorkers face
5 when accessing care. The percentage of foreign born
6 adults without insurance New York has markedly
7 decreased because of the Affordable Care Act.
8 However, nearly half a million—nearly half a million
9 are still uninsured. PPNYC also supports Intro 1668,
10 which will allow the creation of the Health Access
11 Program and expand services in Health and Hospital
12 facilities, non-profit an private medical providers
13 regardless of immigration status and employment
14 status and pre-existing conditions. We are thrilled
15 to see the City Council commit to creating medical
16 hosts for individuals who need care regardless of
17 their history with medical issues. Additionally, we
18 strongly support the implementation of patient—of a
19 patient navigation service through the Health Access
20 Program. Implementing patient navigation services
21 throughout New York City will provide a means to
22 receive the support, referrals and the connections
23 necessary to access care for our most disenfranchise
24 individuals. Planned Parenthood is committed to
25 ensuring that all individuals have access to high

quality care and we strongly support the implementation of the Health Access Program that is implemented correctly will help secure access to primary health services. However, we do have questions about the implementation of the program specifically about the structure of the medical home, the range of services that will be covered and the requirements for participation in the Health Access Program. These are outlined in our written testimony. Given the constant attacks from the federal government on immigrants we must stand up to ensure all New Yorkers have access to quality care. WE applaud—we applaud the City Council for protecting the rights of marginalized groups and safeguarding access to healthcare. Thank you.

CHAIRPERSON LEVINE: And Maryam, we will definitely review your written testimony. We know you have a lot of good questions in there, and we thank you for posing them and for speaking out today on behalf of PPNYC. Thank you.

MARYAM MOHAMMED: Thank you.

CHAIRPERSON LEVINE: Senor Pinzon.

MARYAM MOHAMMED: Whoops.

2 JUAN PINZON: I thank you. Hello, my
3 name is Juan Pinzon and I am the Director of Care
4 Services at the Community Service Society, and I
5 would like to thank Chairs Levine and Rivera for the
6 opportunity to provide these comments. I would like
7 to center my comments on the—the solution, and I
8 think which supports the Resolution, and the bills
9 that are pending before the State Legislature that
10 would allow all New Yorkers to enroll in the
11 legislation plan regardless of their immigration
12 based on income (sic) but regardless of their
13 immigration. CSS health programs help New Yorkers
14 enroll to have insurance coverage and access to care
15 they need. We do this through our live answer
16 headline in partnership with all 50 community-based
17 organizations throughout the state, and we save about
18 130,000 New Yorkers every year. CSS also conducts
19 high level policy research that supports the needs of
20 our constituents. Specifically relevant to these
21 resolutions, CSS authored in 2016 a report that
22 outlines the cost and feasibility offering this
23 sensational plan to New York's immigration
24 populations. Since implementation of the ACA New
25 York has successfully cut it admissions rates in half

2 from 10% to 5% and, in fact, New York was one of just
3 two states in the country that continued to see a
4 decrease in its rate of insurance according to the
5 most recent census data released last month. One of
6 the single most important reasons for our success is
7 the successful implementation of the Essential Plan
8 under the ACA. Today, almost 800,000 New Yorkers
9 have enrolled, which is actually nearly the entire
10 eligible population. Unfortunately, both federal and
11 state immigration restrictions limit coverage options
12 for the roughly 200,000 unauthorized adult immigrants
13 who reside in our state. The proposed legislation
14 would remedy this situation because it would offer a
15 state funded iteration of the essential plan for
16 everyone who meets the income requirements regardless
17 of their immigration status. This is why New York
18 should take this landmark step first. New York has
19 been a historic leader in offering coverage through—
20 through its immigrant races with our federal
21 assistance. For example, it was the first state to
22 offer comprehensive child healthcare coverage to
23 children who got less of the immigration status up
24 tot age 19. Most recently New York City has expanded
25 across—across—expanded access to healthcare for all

2 the initial New Yorkers including all immigrants
3 through the NYC Care program. Second, evidence from
4 the implementation of the ACA has proven that health
5 insurance improves health and financial wellbeing of
6 individuals and communities. Numerous studies
7 indicate that people who have courage and more likely
8 that they ensure counterparts to delayed and
9 preventive care and services for seniors and chronic
10 health conditions. These entries shows that access
11 to coverage is associated with significant reductions
12 in mortality and improvements in mental health and
13 it's in part because of the higher continuity of
14 care. And finally, lack of courage for a significant
15 portion of New Yorkers also causes problems for the
16 broader healthcare system because it causes payers
17 and providers to charge more to the insured
18 population in order to upset the losses in providing
19 care to the uninsured. In 2015, the economy set a
20 National Bureau of Economic research on uncompensated
21 care costs associated with the uninsured to be
22 approximately $900 per person per year. For all
23 these reasons, CSS encourages the New York City
24 Council to pass this important resolution. Thank you
25

2 again for your—for the opportunity to provide these
3 comments.
4 CHAIRPERSON LEVINE: Thank you so much,
5 Juan, and if we could just create space for the mic—
6 in front of the mic for Jeff Remax's Natoli, (sic) is
7 that correct. [background comments/pause]
8 CHAIRPERSON RIVERA: Before Juan, can I
9 ask you one question before—I—I know where you're
10 standing now, but in your testimony there is a note
11 here that said in 2015 that there is the National
12 Bureau of Economic Research attributed uncommon
13 stated care costs associated with the uninsured to be
14 approximately $900 per person per year and that
15 number has undoubtedly gone up since it's a 2015
16 number. So, you know, I—I—I asked Health and
17 Hospitals for this number and I—I wanted to make sure
18 as—as we're looking towards, you know, Community
19 Service Society you all are incredible in terms of
20 data and resources and all the tools that I've been
21 using since I was in Social Services. Um, that
22 number has undoubtedly gone up, and—and I—and I—by
23 your testimony, clearly you support the legislation,
24 but feedback and collaboration between FQHCs and HMH
25 I think is so important. So, I wanted to just point

2 that out in your testimony and—and thank you because
3 I think that that number has gone higher and it's
4 really, really imperative that we're including the
5 FQHCs in this expansion. So, I just wanted to say
6 thank you for that.
7 JUAN PINZON: Could I just add something
8 quickly to that. I actually have a more updated
9 number.
10 CHAIRPERSON RIVERA: Oh, okay.
11 JUAN PINZON: That Urban Institute did a
12 study on the amount of uncompensated care that would
13 be reduced by instituting an individual mandate. So
14 the federal government has gotten rid of the
15 individual—or has zeroed out the penalty for not
16 having health insurance, and states are contemplating
17 what that would mean to institute on a state level,
18 and the estimate that they had is that it would
19 actually be over $11,000 per uninsured person. So, if
20 you take the Coverage for All Bill into
21 consideration, we think 110,000 people would enroll
22 in insurance. That would reduce the state's
23 uncompensated care burden by $130 million a year.
24 CHAIRPERSON RIVERA: Uh-hm. Thank you.
25 CHAIRPERSON LEVINE: Okay, please.

2 NATALIE ENTERANO: Thank you. Thank you
3 for the opportunity to provide testimony in favor of
4 Intro 1668 and Resolution 918 calling on the City and
5 State to expand health coverage for New Yorkers who
6 do not qualify for federal programs. Thank you
7 Council Member Levine and Council Member Rivera. My
8 name is Natalie Enterano and I'm from Care for the
9 Homeless. CFH has 35 years of experience providing
10 medical and mental health services exclusively to
11 people experiencing homelessness in New York City.
12 We operate 20—24 federally qualified and state
13 licensed community health centers in Manhattan,
14 Brooklyn, Queens and the Bronx. Our services are co-
15 located to facilities operated by other non-profits
16 that include shelters for single adults and families,
17 assessment centers, soup kitchens, the Drop-In
18 Centers. Additionally, our community-based health
19 center model brings services directly to
20 neighborhoods where the need is most significant.
21 Both models reduce barriers to homeless New Yorkers
22 whatever they face in navigating the complex
23 healthcare system, and increasing access to high
24 quality care. All services are always provide
25 regardless of the individual's ability to pay. We

2 serve 7,100 patients and 46,000 visits annually. 85%
3 of our clients are at or below 100% of the Federal
4 Poverty limit. Sixty-three percent receive Medicaid
5 and 20% are uninsured. We have often testified about
6 the need to provide appropriate medical and mental
7 health care to New Yorkers experiencing homelessness.
8 Appropriate medical care includes preventative
9 medicine, ongoing treatment and specialty services
10 such as podiatry, optometry, and dentistry, which are
11 vital to vulnerable and often under-served
12 populations, but do not then have easier community
13 access to essential services hindering opportunities
14 to work, the ability to maintain healthy lives and to
15 obtain and keep permanent housing. We consider what
16 we do a specialty because of how long it takes to
17 gain the truest of our clients. Trust is something
18 that we take very seriously, and in this climate it
19 is imperative to not only increase access to medical
20 services, but to provide access to the high quality
21 services afforded to all New Yorkers. We applaud the
22 city in its efforts to introduce NYC Care to
23 communities most in need, and we are extra supportive
24 of the initiative to include the vast network of
25 Community Health Centers located in the very

2 communities where uninsured residents live.
3 Community Health Centers like CFH work hard to gain
4 the trust of the communities that we serve, and are
5 well equipped to carry out the NYC Care mandate.
6 Last year we had a mother and a daughter come to our
7 health center who had been using our services for
8 many years. At the end of the visit we tried making
9 a referral to another facility and the mother
10 absolutely refused to go because she feared accessing
11 any service outside of our facility would jeopardize
12 here status in the United States. This the necessary
13 facility that she decided to forego because she did
14 not trust another—another healthcare provider.
15 Stories like these are not uncommon and really speaks
16 to the power that Community Health Centers hold in
17 providing the necessary services to address the
18 health needs of the community. Even as medical care
19 is legal and more accessible, the fact is we must
20 work harder to provide access to vulnerable
21 populations that often fall or are excluded from the
22 safety net. We want to thank you—thank both the
23 Health and Hospitals Committee and the City Council
24 for also making a commitment to increase access to
25 healthcare for uninsured New Yorkers. We look

2 forward to partnering with you while continuing our
3 mandate to provide high quality comprehensive primary
4 care services to anyone seeking care regardless of
5 insurance coverage, income or immigration status.
6 Thank you.
7 HOLLY NATIAGA: Well, good afternoon.
8 CHAIRPERSON LEVINE: Yes, please, yes.
9 HOLLY NATIAGA: I am not Paloma. Paloma
10 had a family emergency. So, please excuse us. I'll be
11 saying her statement in summary. My name is Holly
12 Natiaga (sp?). I'm the AVP of the Group Network and
13 Executive Initiatives of the Urban Health Plan. So
14 Urban Health Plan is a federally qualified healthcare
15 center that we serve about 90,000 individuals in
16 Corona, Queens, the South Bronx and in Central
17 Harlem. Over the last past 45 years our organization
18 has come from one site to 29 practicing sites in that
19 three boroughs. At Urban Health Plan we took a great
20 pride in providing true community based health center
21 and the gorgeous healthcare. In 2016 and 2017, Urban
22 Health Plan along other FQHCs, Health and Hospitals
23 in a city-led effort called Action Health. This
24 program was a multi-agency year-long demonstration
25 project led by the New York State Department of

Health and Mental Hygiene. The aim was to increase access to healthcare for those who are uninsurable. At first hand we were able to see favorable results. We were able to see our patients in our cohort receive many preventative services including hypertension, Diabetes, weight control, cholesterol, tobacco use, access to depression, Colorectal screenings and HIV, and more important, all our patients got their flu shots. Just putting out there it's flu season. Get your flu shot. Our patients at Urban Health Plan 4 on 1 linked to case managers that help them navigate systems where they needed to get specialty care. Currently, we're working with Health and Hospitals around New York City Cares, and we're seeing similar results. We hope to see access to quality care increase in a way—in a way that is effective and systematic. This expansion is critically important in reducing health inequalities. The lack of money will no longer be—will no longer be a barrier, but it will be--On the contrary. This program will help level the playing field for those involved in the program. Having such a large number of uninsured patients, federally qualified health centers are actually aware of the difference of how

2 many can be a barrier to healthcare. Urban Health
3 Planning all the communities that we serve we thank
4 you for including FQHCs in part of this program, and
5 we look forward to working with Health and Hospitals,
6 the City Council, and the City of New York City to
7 make sure that healthcare is not a right—is a right
8 not a privilege. Thank you.
9 CHAIRPERSON LEVINE: Thank you much.
10 Have you had your flu shot?
11 HOLLY NATIAGA: Yes, I did.
12 CHAIRPERSON LEVINE: Good answer. You
13 were really in trouble otherwise. Thank you to this
14 excellent, excellent panel. It's going to be hard to
15 top, but I think we can do it. Continuing the parade
16 of healthcare leaders we have Carlyn Cowen from the
17 Chinese-American Planning Council. [background
18 comments/pause] And—I'm sorry. Michael Pereira from
19 the Hispanic Federation; Mary Ford from Primary Care
20 Development Corporation; and also Patrick Kwan from
21 PCDC; Jessica Diamond from Hudson River Health Care
22 as well as Hope Glassburg also from Hudson River
23 Health Care. [background comments/pause] Welcome,
24 and Carlyn, do you want to kick us off?
25

2 CARLYN COWEN: Absolutely. Good
3 afternoon. My name is Carlyn Cowen and I'm the Chief
4 Policy and Public Affairs Officer of the Chinese-
5 American Planning Council, CPC. Thank you very much
6 Chair Levine for the opportunity to testify today and
7 for hosting this hearing. CPC is the nation's largest
8 Asian-American social services agency providing
9 services for over 60,000 New Yorkers in all five
10 boroughs for community members coming from 40
11 different countries and 25 different languages. We
12 are pleased to testify today in support of the Intro
13 expand NYC Cares as well as well as the resolution in
14 support of passing the essential plan, both of which
15 we think are extremely important for our community
16 members that we serve at CPC. Every year at CPC we
17 do an annual survey of the most urgent issues facing
18 our staff and community members and every year
19 healthcare access tops the list for that survey.
20 Fully one in four community members that walks
21 through CPC's doors do not have access to health
22 insurance. Overall, 1 in 5 Asian-Americans lack
23 access to health insurance entirely. These are
24 community members that use the emergency room as
25 their primary care, if they use it at all. These are

2 community members that do not have access to any of
3 the public option programs and would be greatly
4 served through the expansion of NYC Cares, and the
5 expansion of the essential plan. What this really
6 means in human terms for the community members that
7 CPC serves is that instead of providing the services
8 that we really need to help our community members
9 thrive, what CPC staff spend our time doing is
10 pleading with our community members to go to the
11 emergency room because we know they are so sick that
12 they need care when they don't want do it. We sit
13 with our community members and help them decide if
14 they should go to the doctor and refill their
15 prescriptions or pay their rent that month or put
16 food on the table. These are the real daily lived
17 experiences of our community members because the
18 cannot get the care that they need. In today's
19 immigration climate, what we see is this is becoming
20 even more of an urgent issue. While we had a victory
21 with the public charge injunction recently, in a lot
22 of ways the damage has already been done as community
23 members are dropping off of their public programs,
24 and with the most recent health insurance
25 proclamation, what we can see is what the federal

2 administration is doing is beginning to use our
3 health insurance programs as part of the deportation
4 machine, and people's insurance status is being
5 wielded against them to separate families. What this
6 means is that New York City and New York State must
7 take a strong stand to ensure that all community
8 members regardless of immigration status, regardless
9 of the ability to pay have the healthare that they
10 need, and programs like NYC Cares have been essential
11 in doing this, and the essential plan being expanded
12 to community members regardless of status would also
13 be critical in this. While CPC is fightin for
14 transofrmative healthcare programs like the New York
15 Health Act and like Medicare for All that will help
16 all of of our community members get the care that
17 they need and deserve. These programs are incredibly
18 imkportant as we fight for broader programs because
19 they will meet the immedidate needs of our commuity
20 members that are in dire straits every day. Thank
21 you so much for your support of these programs.
22 CHAIRPERSON LEVINE: Thank—thank you,
23 Carlyn. Can you remind me what neighborhoods your
24 facilities are in?
25

2 CARLYN COWEN: Our community centers are
3 based in Manhattan, Chinatown, Flushing and Sunset
4 Park, although we have 33 different sites throughout
5 the five boroughs.
6 CHAIRPERSON LEVINE: And how many—how many
7 individuals do you see annually?
8 CARLYN COWEN: We see 60,000 each year,
9 9,000 a day.
10 CHAIRPERSON LEVINE: That-that-that's a
11 very—that's a very large number. Can you comment on
12 the climate of—of the feelings now of the immigrants
13 that you serve with—with the attacks from the White
14 House and elsewhere, and how that might impact their
15 wiliness to access medical care?
16 CARLYN COWEN: Absolutely. They have
17 created just an incredible climate of fear. We saw
18 people lined up outside of our doors after public
19 charge trying to de-enroll from health insurance.
20 After the news of the healthcare proclamation came
21 out, which would restrict access to people trying to
22 enter the United States based on their ability to
23 have health insurance. We had communities members
24 streaming into our centers saying what's going to
25 happen for this family member that I'm sponsoring

2 that I'm trying to petition to come with me? It is
3 completely changing people's relationship to
4 healthcare, which has already been difficult based on
5 affordability, but now it's also based on immigration
6 status as well.
7 CHAIRPERSON LEVINE: And we certainly
8 hear anecdotal stories of immigrants who are avoiding
9 seeking medical care because they don't want to
10 appear on the systems of any organization, and that
11 should scare everybody. That should scare people who
12 care about the welfare of immigrants, but, you know,
13 when it comes to public health we're all in this
14 together because many diseases are contagious and,
15 um, I don't care who you are and what you ideology is
16 or what your immigration status is, you should be
17 really scared about a world where anyone in the city
18 is refusing medical care, and to the extent that
19 organizations like CPC are on the ground who are
20 breaking down the trust barriers and bringing people
21 in, it's more important now probably than at any
22 point in the history of you organization. So, thank
23 you to CPC and for outspoken leadership, Carlyn, on
24 these issues. Thank you.
25 CARLYN COWEN: Thank you.

2 CHAIRPERSON LEVINE: Please.

3 MICHAEL PEREIRA: Good afternoon. My name
4 is Michael Pereiera. I am the Health Outreach
5 Coordinator at Hispanic Federation, the nation's
6 premier Latino membership organization founded to
7 address many inequities confronting Latinos and non-
8 profit organizations that work directly with them.
9 For more than 25 years the Hispanic Federation has
10 provided grants, administrative human services and
11 coordinated advocacy efforts for our board and
12 network of agencies. Collectively the federation
13 serves more than two million Latinos in the area of
14 health, immigration, economic empowerment, civic
15 engagement and education. Today, we are testifying on
16 behalf of Hispanic Federation's health service
17 providers and the Latinos [speaking Spanish] Hispanic
18 Federation's AIDS Leaderships Group comprised of 30
19 New York City agencies with long histories of
20 services to diverse groups of Latinos. First and
21 foremost, I'd like to thank the New York City Council
22 for welcoming us here today and listening to our
23 testimony in support of the Council's Resolution
24 focusing on coverage for all as an essential plan
25 bill, and the New York State legislation. We applaud

2 the New York City Council for calling on the Assembly
3 Members, State Senators and on the Governor to pass
4 and enact S.3900 and A.5974, which would expand
5 eligibility for the essential plan to individuals who
6 currently face barriers to health and care coverage
7 due to the immigration Status. New York is often
8 defined as a beacon or immigrants, an should be
9 leading the way in ensuring that every New Yorker has
10 access to healthcare regardless of immigration
11 status. Barriers to accessing healthcare—health
12 insurance is a public health concern that affects
13 more than 400,000 New Yorkers. Those without health
14 insurance often wait until they are in excruciating
15 paint or at risk of dying to go to the emergency room
16 just to receive care. Not only is this dangerous for
17 the individual and the needs of services, but also
18 comes at a monetary and societal cost to the larger
19 community. Hispanic Federation believes that
20 regardless of one’s immigration status, whether
21 you’re a DACA recipient let 42,000 other New Yorkers
22 or a TPS holder like some 33,600 New Yorkers,
23 everyone should be able to see a primary physician on
24 a regular basis for their healthcare needs. Health
25 is not a luxury. It is a basic human right and

2 necessity. Being insured has life saving implications
3 Not only is Coverage For all a sound public health
4 policy, but having health insurance means that our
5 community will have access to primary care, physician
6 and preventative care. It means our neighborhoods
7 will have access to annual physicals, and regular
8 checkups. It means symptoms will be reported when
9 they are first noticed without fear of going into
10 debt, or worse, waiting until the pain is unbearable,
11 visiting the emergency room and finding out it's too
12 late to do—to have anything be done. Coverage for
13 All is a mechanism for New York State to invest in
14 healthier communities, and better our entire society.
15 Thank you.
16 CHAIRPERSON LEVINE: Thank you, Michael
17 and thank you to the Hispanic Federation for
18 supporting this. I have just learned that there's
19 another committee waiting for their hearing in this
20 room. Not to worry. Everyone who signed up to speak
21 will absolutely have that opportunity, and we have
22 two more panels, but unfortunately, we're going to
23 have to start using the two-minute clock. I
24 apologize. We just want to make sure that everyone
25

2 gets a chance to go on the record before we're kicked
3 out of here. So, please, take it away.
4 HOPE GLASSBERG: I'll make the two
5 minutes count. My name is Hope Glassberg. I'm the
6 SVP of Government Affairs and Strategies at Hudson
7 River HealthCare, which is a federally qualified
8 health center network with 43 locations across the
9 Hudson Valley, Long Island and New York City. We
10 were started in the mid 1970s by four Asian-American
11 mothers who created a community health center because
12 they weren't able to travel up to two hours or more
13 for care for their children. So, that's really our
14 rich legacy and history and continues today as we
15 continue to support the notion that healthcare is
16 very much a right and not a privilege. So, with that
17 we're very excited to be here today. In 2018, Hudson
18 River Healthcare merged with Bright Point Health,
19 which is a federally qualified health center network
20 with sites in all five boroughs of New York City, and
21 in affiliation with the Community Health Action
22 Network of Staten Island, where were provide a number
23 of Social Services and supports, and my colleague
24 Sean Leahy will tell you a little bit more about
25 those services. As, you've heard from a number of

2 the other presenters, what makes the QHC model unique
3 and special is that we offer not only medical care,
4 but the social supports, behavioral care, substance
5 use disorder treatment, medication assisted
6 treatment, the full gamut of social and healthcare
7 needs in a single location so that we can meet our
8 patients where they are. And so another—another
9 aspect about QHCs that I want to highlight because I
10 think it's really important as-as the Council
11 considers this Intro 1668 is that our government
12 structure is such that we have a majority of
13 consumers on our board for helping us make our
14 decisions, and direct the future of our organization.
15 We also have community advisory boards in all of the
16 communities where we exist that help us outreach to
17 the community to share information not only about our
18 health services, but also to dispel myths about
19 public charge and other policies that unfortunately
20 impede access to care. We've had a great dialogue
21 thus far with the leadership of the New York City
22 Cares program as it is rolled out in the Bronx, where
23 we do have some sites, and we're very hopeful that
24 some that some of the steps that the program has
25 taken to identify whether potential members are

2 already connected to care when folks call into the
3 call center will be effective, but we believe that
4 this initiative will help further strengthen the
5 partnership between that program and exiting FQHCs
6 particularly in communities where there may not be a
7 Health and Hospitals facility. We think this is a
8 matter not simply of just resources being made
9 available to FQHCs to support a robust primary care
10 network but also an opportunity to engage in joint
11 marketing and community education leveraging those
12 advisory boards and consumer leadership we mentioned.
13 Thank you so much for your consideration today, and
14 we really appreciate the Council holding this hearing
15 today.
16 CHAIRPERSON LEVINE: Thank you, Hope.
17 Your—your—your punctuality is a model for Council
18 Members everywhere, and I didn't know that founding
19 story about Hudson Valley Healthcare.
20 HOPE GLASSBERG: Yes
21 CHAIRPERSON LEVINE: Hudson River
22 Healthcare. Excuse me.
23 HOPE GLASSBERG: Yes.
24
25

2 CHAIRPERSON LEVINE: Which is a perfect
3 example when I was speaking about the origins of this
4 movement, which grew out of the Civil Rights Era
5 HOPE GLASSBERG: Absolutely.
6 CHAIRPERSON LEVINE: So thank you for
7 sharing that.
8 HOPE GLASSBERG: Thank you.
9 CHAIRPERSON LEVINE: Please.
10 MARY FORD: Great. Thank you for the
11 opportunity to testify before the committee today.
12 I'm Mary Ford. I'm the Director of Evaluation and
13 Analytics with the Primary Care Development
14 Corporation. PCDC is a New York based non-profit
15 organization and a U.S. Treasury certified community
16 development financial institution that was founded as
17 a public/private partnership by the City of New York,
18 including the City Council, and we always have a
19 Council Member serving on our board, which is
20 currently Chair Mark Levine. Our mission is to
21 create healthier and more equitable communities by
22 building, expanding and strengthening primary care.
23 Over the last 25 years PCDC has provided capital and
24 technical assistance to over 400 healthcare sites
25 across the five boroughs. We've also financed it and

2 have healthcare facilities in 50 of the City Council
3 districts, and this includes financing. Half of all
4 FQHCs in New York City. So, as a capacity building
5 program, PCDC has trained and coached more than
6 9,0000 health workers to deliver superior patient
7 centered care including working with New York City
8 Health and Hospitals where we've provided technical
9 assistance for ambulatory care redesign for over 15
10 years, and so what I'm here to talk about today is
11 that since 2017, PCDC has received a generous
12 discretionary award from the New York City Council
13 that recently we've been using to examine primary
14 care access across the city specifically at the City
15 Council District level. This analysis is the first
16 and only City Council district level assessment of
17 primary care access, and we're very thankful to the
18 City Council for their support. We found significant
19 disparities and inequities in access to primary care
20 in many of the Council Districts. In particular,
21 there are very stark differences in the ratio of
22 primary care providers to constituents and residents
23 in some Manhattan districts, which is actually
24 represented by member Rivera. There are up to 64
25 [bell] primary care providers whereas only two

2 primary care providers per 10,000 residents in the
3 areas of Brooklyn and Queens. That means some
4 Council Districts have more than 20 times the number
5 of providers than in other districts, and these
6 districts with few primary care providers are often
7 characterized by high poverty, unemployment and
8 higher rats of Diabetes and potentially preventable
9 emergency room visits. Of course, I think one things
10 just to emphasize it, the primary care safety net is
11 that our research does note that providers in higher
12 poverty communities are more likely to accept
13 Medicaid and Medicare and be patient-centered medical
14 homes, which means that they are responding to many
15 of the needs that are really critical in these
16 neighborhoods. I'd say I summary literature does
17 show that more primary care providers in the
18 community results in better outcomes, which
19 definitely holds true, and we provided you all with
20 some reports that are both district-specific and
21 citywide on this today. So, strategic supporting
22 investment in primary care is essential to achieving
23 health equity. I'm going to turn it over to my
24 colleague Patrick so…
25 CHAIRPERSON LEVINE: Thank you.

2 PATRICK KWAN: Sure, hi. My name is
3 Patrick Kwan. I'm the Senior Director for Advocacy
4 and communications for the PCDC. So, New Yorkers
5 need hospital beds for when we are seriously sick and
6 we need emergency rooms for emergencies, but what we
7 also need is we need primary care services to help us
8 stay healthy, maintain our health and also avoid
9 costly hospital stays and emergency room visits. We
10 were founded in 1993 but the Administration on
11 Public/Private Partnership. At that time the New
12 York Times did a front page story about how only 28
13 properly qualified doctors to serve a population of
14 1.7 million people in nine low-income neighborhoods
15 in Harlem or Central Brooklyn and South Bronx, and as
16 we know many of these disparities continue to persist
17 and while the—a lot of the infrastructure for the
18 primary care has improved dramatically over 25 years,
19 as we've indicated in the primary care files. I also
20 want to talk about that the New York underserved
21 communities need primary care services most, and
22 relying on many of the folks here today who lack the
23 resources to expand and improve services, and while
24 the City Council has made important and generous
25 investments in community providers, these investments

2 have not and will not meet its substantial capital
3 needs, and we are speaking as a U.S. Treasury
4 Certified Community Development Financial Institution
5 with a mission to include bring our expertise in
6 financing community-based healthcare, and one of the
7 strategies that we hope the City Council will
8 consider is what we've been doing for the last 25
9 year across the Administrations to use a variety of
10 capital instruments including public and private loan
11 loans and capital grants to enable more and larger
12 projects to the immediate and their substantial needs
13 in communities, and some of the recent financing that
14 we've done in New York City for projects such as
15 Aperture in Lower Manhattan, Callen-Lorde n Downtown
16 Brooklyn, the ICO for the East New York Health Club
17 and the Addabbo Family Health Center in Rockaways
18 have utilized federal New Markets Tax Credits, New
19 York State Community Healthcare Revolving Capital
20 Funding, and private investment in additional City
21 Council grants. We look forward to working with City
22 Council on more comprehensive strategies to maximize
23 the grant funds for financing primary care
24 infrastructure expansion and take advantage of some
25 of the many resources out there, the capital

2 instruments to make sure that we have comprehensive
3 strategy, utilizing the resources at every level to
4 make some of these projects possible. Thank you.
5 CHAIRPERSON RIVERA: If I could just ask
6 you a question because you presented some—some data
7 in terms of the stark differences and clearly my
8 community is—is better resourced, by for the 20 times
9 more providers in some districts than others, what
10 did you find were some of the major challenges?
11 MARY FORD: So, the major challenges for?
12 CHAIRPERSON RIVERA: In terms of why
13 there were so few primary care providers? Do you
14 thing it's—it's just that the wealth gap? Was it
15 geography? Like what are some of the things that we
16 can try to do overcome some of these immense
17 challenges?
18 MARY FORD: Yes, so I think definitely
19 the wealth gap would be one reason, but I do think in
20 New York it's a little bit unique just because of how
21 dense many areas are. The communities with the
22 fewest primary care providers are areas in Queens,
23 Central Brooklyn that are really under-resourced
24 across the board, and so, one—again the strategies
25 that my colleague is recommending and we, of course,

2 are in support of it, PCDC is really investing in
3 more primary care. So siting more facilities,
4 expanding existing facilities, renovating and
5 renovating so that there are again more providers
6 more availability, and increased access in
7 communities that don't have them currently and then,
8 um, and then, um, yeah, working with existing
9 organizations where there are—where there are PCPs to
10 make sure that, um, residents nearby are able to
11 access them.
12 CHAIRPERSON LEVINE: And I just want to
13 say I know PCDC very well and I don't think people
14 realize how hard it is for community-based health
15 Centers to get financing. If you are a major
16 hospital system with $7 billion in revenue, you're
17 probably going to be able to do that all by yourself,
18 but for these smaller non-profits they really do need
19 an ally like PCDC, and that then translate then to
20 more patients served in more neighborhoods and so
21 your work is behind the scene, but really, really
22 important, and we're grateful for that.
23 SEAN LEAHY: Thank you.
24 CHAIRPERSON LEVINE: Please.
25

SEAN LEAHY: Good afternoon. I'm speaking here for Jessica Diamond. My name is Sean Leahy. I'm also with Hudson River Healthcare. I want to tell you briefly about our New York City Division Bright Point Health. Hudson River Healthcare formerly known as Bright Point Health. So, as Hope mentioned, we have locations in all five boroughs including the expansion of our new clinic and urgent care East Brooklyn in January of 2020. Some of our services currently include primary care, behavioral health, substance abuse treatment and other specialty and social support services. I like many of the other s here sever vulnerable populations in our city many of which are homeless, and uninsured and Hudson River Healthcare is in full support of Intro 1668 and thank you for your leadership to see this through.

CHAIRPERSON RIVERA: Well thank you. Thank you so much. I'm going to call the next panel. Wynn Perry Yassamay (sp?) and please let me know if I mispronounce your name; Andrea Bowen, Leon Bell. Let's see. Jabanga Awanusi (sp?) Anthony Feliciano, and Adelle Flatasue [background comment] Flateau.

2 Adelle Flateau. [background comments/pause] Is this
3 everyone? No. I think I'm missing someone.
4 FEMALE SPEAKER: They may have left.
5 CHAIRPERSON RIVERA: Yeah. Okay. You can
6 begin.
7 ANDREA BOWE: Good afternoon, Chair
8 Rivera and, um, Council staff. [laughs] How, my
9 name is Andrea Bowen. Um, Principal of Bowen Public
10 Affairs Consulting, but today I'm here as also a
11 coordinator of the Transgender, Gender Non-Conforming
12 and Non-Binary or TGNCNB Solutions Coalition, which
13 is the coalition of various organizations, New York
14 City Anti-Violence Project, Make the Road, GMHC and
15 Action Network, and Sylvia Rivera Law Project to meet
16 the needs of TGNCNB New Yorkers. Thank you and Chair
17 Levine, our bill sponsors and staff from the
18 Committees on Health and Hospitals for your amazing
19 advocacy helping make possible the baselining of the
20 LGBTQ community outreach workers program and thank
21 you for the bills that were introduced today. So,
22 I'm just going to make a couple of quick points in a
23 minute [laughs] that sort of relates to TGNCNB
24 Communities and what's—what's at hand today. With NYC
25 Care it's of paramount importance to our coalition

2 that the NYC Care cover transition related care being
3 care that's specific to the need of the TGNCNB
4 community. We intend to work with H&H to outline
5 which transition related care treatments are covered
6 by NYC Care. We haven't started that project in
7 earnest yet, but I just wanted to highlight it and
8 we're—we've started the conversation a couple months
9 ago. With 1688 we support the efforts to ensure
10 widespread mobilized system of primary care provision
11 but what we would like to see is data collection on—
12 we want to make sure that the patient navigators are
13 referring people to population specific navigators
14 like the outreach for the LGBTQ community outreach
15 workers, and that that data is tracked, and we
16 provided some redlined data in our redlined language
17 in this testimony that sort of explains that. [bell]
18 Also regarding the res, we support that and we just
19 wanted to add a little bit of our redlined language
20 also that mentions that any essential plan needs to
21 cover transition related care, which is already the
22 law in New York, but still worth noting. So, we thank
23 you very much for your time, and if you have any
24 questions on my testimony, happy to answer,
25

2 CHAIRPERSON RIVERA: And—and just want to
3 let you know we're going to make sure that your
4 testimony is on the record, and we realize two
5 minutes is not a lot of time. So, just know your
6 testimony will all be read into the record, and we do
7 appreciate it, and it's summarizing it. Thank you.
8 Mr. Bell.
9 LEON BELL: I would like to thank the
10 Committee. My name is Leon Bell. I'm from the New
11 York State Nurses. I'm going to be very brief. I
12 just want to make a couple points. Obviously we
13 support Intro 1668, Resolution 198. I would add that
14 as a further step in the process I think it's
15 important for the—the council to consider expanding
16 the scope of the, um, the New York City Care Program
17 by forcing, coaxing or shaming the private hospital
18 systems to pick up their share, and I think that
19 would address a lot of the questions that were raised
20 about the costs of adding the services necessary to
21 meet the population needs. I would also just like to
22 point out that our data is pretty readily available
23 on the State Department of Health website. It shows
24 that Medicaid enrollments are down between March of
25 2018 when the Trump Administration unveiled its new

2 public charge planning and through October that the
3 Medicaid enrollments are down about 150,000. I don't
4 believe that's a function of the Trump economy or
5 economic boom. I think it's a function of people
6 being afraid to sign up and take benefits that they
7 are otherwise entitled to because we haven't see any
8 real expansion of other enrollments in other programs
9 that will sort of indicate the people are switching
10 out of Medicaid and into other coverage, and I think
11 what that gets to when we talk about New York City
12 Care and one of the things HHC was here for a long
13 time and seems to have left, but I would recommend
14 that the Council and HHC or Health and Hospitals look
15 at the issue of the hoops or the steps that are
16 required for people to enroll in the new program, and
17 that they should seriously consider making I a much
18 simpler process where people just come in and say I'm
19 uninsured and I'm a New York City resident, and they
20 should be enrolling people without requiring a lot of
21 documentation because I think that's one of the
22 issues at play with the [bell] reduction in Medicaid
23 services. Thank you.
24 ANTHONY FELICIANO: Good afternoon. My
25 name is Anthony Feliciano. I'm the Director of the

2 Commission on the Public Health System, and we are
3 not going to go through my whole testimony, but I'll
4 say here we are major supporter of not only NYC Cares
5 Program, but we also support both resolutions and
6 bills on strengthening and enhancing it for more
7 communities. I just want to remind us that there are
8 two major things that impacts us right now for this
9 and any programmer. One, we still have uncomplicated
10 care, and the original care pool not properly
11 distributed to—to real safety net hospitals. So that
12 makes an impact to the programs like this. And then
13 the other is what Leon had mentioned around the—the
14 dip in the Medicaid enrollment, and the real—and the
15 main reasons really coming from fear of the federal
16 administration's onslaught on our community our
17 communities particularly immigrant communities and
18 all marginalized communities. So that's a—even though
19 it is not into law the public charge, it did its
20 intended consequences, that they wanted it to do.
21 The Administration wanted to put the fear in
22 immigrant communities and make them disenroll and not
23 come into hospitals or any healthcare system
24 location. I want to put in recommendations.
25 Supporting state engagement H&H has done good with

2 working with CBOs, cultural competency as to enhance
3 and work with NYC Cares program, but I still think
4 many of our partners have said that is not enough.
5 The investment into the CBOs didn't cover what they
6 can do and there's a lot of work to do even though
7 they succeeded in doing it, but it really needs to
8 look at the smaller CBOs and how you—what's the
9 funding like for them to continue doing this. The
10 other party is obviously reaping these trends from
11 any rollout by bringing in the FQHCs and the primary
12 care providers because of their overall important
13 part of the safety net, and so we want to make sure
14 that that is really addressed and that's why we
15 support the resolution of the bill, but we also think
16 the funding is not enough. I maybe very
17 politicalist, but the Mayor used this as his campaign
18 slogan and running for the president that had to go
19 beyond that, and then you had to really invest and
20 you care about communities and you invest in the
21 FQHCs being equal partners there. And I will just
22 add that in terms of ensuring evaluation of the
23 program, in terms of costs to know that and the third
24 piece I think we haven't touched on that we all hear
25 constantly because we have not really designed and

2 worked in creating real community health planning. We
3 lack that in this city and this state, and part of
4 that is also not addressing the inequity of how
5 private hospitals and other entities have taken
6 advantage of our safety net in terms of who they
7 serve particularly the most under-served. So, thank
8 you.
9 GWEN CHIASONI: Hello, my name is Gwen
10 Chiasoini (sp?) I'm am a fellow with Physicians for
11 National Health Programs, New York Metro Chapter and
12 I'm also a law student at Fordham University. So, in
13 my current work I work with both med students and
14 doctors fighting for guaranteed healthcare statewide
15 and nationally. Our students and providers work in
16 public hospitals as well as community health centers
17 alike, and with immigrant patients both with and
18 without status. Our students have spoke of learning
19 in clinics and in class ways to navigate getting
20 health—getting healthcare for their patients who are
21 uninsured or under-insured. This is a part of what
22 they're learning every day as they're trying to learn
23 how to become doctors as well, and that's just not
24 right. Many patients—many of these patients are
25 undocumented. All of this is frustrating, and PNHP

2 and New York Metro wants to see more for immigrant
3 patients. While we are fighting primarily for
4 guaranteed healthcare thorough the New York Health
5 Act, and the—through state and national single pair.
6 (sic) We support our coverage for our colleagues and
7 support the essential plan bill on the state level
8 Guaranteed immigrant healthcare is cost-effective and
9 it's humane. We stand with Coverage for All as we
10 fight for guaranteed healthcare statewide.
11 Healthcare should be a human right and should be the
12 norm no matter your insurance—your insurance status,
13 immigration status, income. No matter what. Thank you
14 so much.
15 ADELLE FLATEAU: Good afternoon, Chairman
16 Levine and Council Members. My name is Adelle
17 Flateau and I'm here to testify on behalf of the
18 Alliance for healthier communities North and Central
19 Brooklyn. The Alliance is a partnership with three
20 federally qualified health centers in Brooklyn, which
21 are also members of CHCANYS, the three centers in—
22 three centers include Bedford-Stuyvesant Family
23 Health Center, Brooklyn Plaza Medical Center and
24 Brownsville Multi-Service Family Health and Wellness
25 Centers. By way of background, I have 30 years of

2 experience working directly in healthcare as an
3 executive as well as being a community advocate. I've
4 held senior level positions in the private sector as
5 well as in the public sector for NYC Health Plus
6 Hospitals from which I am now happily retired.
7 According to data provided by the New York City
8 Department of Health and Mental Hygiene Community
9 Health Profiles, the Alliance Health Centers are
10 facing some of the most drastic health outcomes,
11 mortality rates and disparities in New York City. In
12 Brownsville Community District 16, 13—20% of women
13 have late or no prenatal care, double the 6.7% rate
14 for New York City overall. In all of our districts,
15 childhood asthma emergency room visits exceed New
16 York City overall with extremely high rates for
17 Bedford-Stuyvesant and Brownsville. Childhood
18 obesity rates in Bedford-Stuyvesant, Brownsville and
19 East New York exceed New York City overall. This
20 means that more than one out of every five children
21 in grades 8- K through 8 are considered obese.
22 Premature death rates before age 65 summarize the
23 health inequities facing our communities. The rate
24 of premature death per 100,000 population is 169 for
25 New York City overall while it is 178.7 for CD2, 283

2 for CD3, 264 for CD5 and an astounding premature
3 death rate of 365 for Brownsville more than double
4 New York City's rate. [bell] I'm just going to skip
5 to the end. Sorry. Whoops. We urge he New York City
6 Council and Administration to develop and implement a
7 health access program, which will be integrated with
8 the vital safety net services of FQHCs. Thank you for
9 the opportunity to speak with you today on behalf of
10 the Alliance for Healthy Communities North and
11 Central Brooklyn.
12 CHAIRPERSON LEVINE: Thank you very, very
13 much, and here is an excellent panel so I'm told. I'm
14 going to have to review the video tape later.
15 [background comments] [laugher]
16 FEMALE SPEAKER: Well, that's it.
17 CHAIRPERSON LEVINE: I have no doubt.
18 Thank you very, very much for supporting this
19 legislation.
20 CHAIRPERSON RIVERA: And I wad to add
21 that Health and Hospitals and the Department of
22 Health they are still here, and they are still
23 listening. So, thank you.
24 CHAIRPERSON LEVINE: Okay. Well, we
25 decided to save the best panel for last, no pressure.

2 Mia Soto from the New Yorker from NYLPI New York
3 Lawyers for the public interest; Doma Antonales (sp?)
4 from New York Legal Assistance Group, MYLAG. Hope I
5 said that right. Bran Fuss from—I'm sorry I'm having
6 a hard time reading the organizations, but Tacia
7 Raman from the Coalition of Asian-American Children
8 and Families; Monya Cue from the Academy of Medicine
9 and finally Nicole White. [background comments/
10 pause]
11 MIA SOTO: Good afternoon. My name is
12 Mia Soto. I'm a community organizer at the New York
13 Lawyers for the Public Interest at the Health Justice
14 Program. Thank you to Chairperson Levine and
15 committee members for giving the opportunity to
16 present testimony today. For the past 40 years New
17 York Lawyers fore the Public Interest has used
18 testimony and civil rights and legal services to
19 advocate for New Yorkers marginalized by race,
20 poverty, disability and immigration status. Our
21 Health Justice Program that brings a racial justice,
22 immigrant rights focus, a healthcare advocacy in New
23 York City and State in partnership with community-
24 based organizations and coalitions. We work to
25 advance our four broad goals, which were—which are

2 challenge health disparities in immigration as make
3 this nation system—systematic and institutional
4 barriers in the way universal access to healthcare,
5 promote immigrant language and access to health and
6 general system of determinants of health. NYLPI is
7 also here as a member of healthcare for all campaign,
8 an campaign to expand coverage for all New Yorkers
9 led a coalition of community members, community-
10 based organizations, healthcare providers, legal
11 service providers, and advocates for labor, immigrant
12 healthcare, consumer advocates. Our objective is to
13 create a Citywide health insurance product for New
14 Yorkers who are excluded eligibility for coverage
15 because of harmful, shameful disparities and
16 inequities based on race, ethnicity, nationality and
17 language, gender identity and other factors. We
18 firmly believe that all New Yorkers have the right to
19 access the care they need in their communities and we
20 sincerely hope that the Council prioritize immigrant
21 communities and particularly immigrant health by
22 allocating the funding necessary to provide that
23 state funded plan for all New Yorkers. Right now
24 there are more than 400 New Yorkers who could not
25 enroll in health insurance because of health

2 insurance discrimination exposing them to further
3 risk of their organizing injury. NYLPI has been
4 advocating for equity and health justice for New
5 Yorkers marginalized by race and immigration status
6 for decades, and we urge the Council and the City
7 New York to take action to support access to care for
8 immigrant New Yorkers. [bell] Lastly, I want to
9 personally thank the members of the Council and the
10 advocacy by the City of New York for all your actions
11 and in support for us and our goal of our populations
12 in the city. Thank you.
13 CHAIRPERSON LEVINE: Thank you and thanks
14 to NYLPI what you do in your Healthcare Access
15 program is just so important more than ever, and I'm
16 really glad the City Council can help support that
17 effort.
18 MIA SOTO: Thank you.
19 CHAIRPERSON LEVINE: Thank you. Please.
20 DOMNA ENTENADES: Hi. I'll be trying to
21 summarize this. Thank you. My name is Domna
22 Entenades (sp?) and I am a Senior Staff Attorney at
23 the Legal Health Division of the New York Legal
24 Assistance Group. We are in support of Resolution
25 918. Legal Health is the nation's largest

2 medical/legal partnership with legal clinics at 36
3 New York City health facilities. Healthcare providers
4 Routinely refer undocumented patients to our on-site
5 clinics because in many situation without insurance
6 the medical team cannot treat the patient following
7 normal standards of care. My testimony will focus on
8 undocumented access to life saving treatments. Over
9 the past five years a the Bellevue Cancer Center, I
10 have worked with over 225 undocumented cancer
11 patients whose doctors could not provide life saving
12 or life improving treatment because of their status.
13 In the same time period Legal Health has worked with
14 other 1,750 patients in a similar position. Many of
15 Legal Health and most of my clients died in part
16 because of the time realities of legal advocacy and
17 navigating bureaucratic red tape. A premature death
18 can mean economic instability for a family who relied
19 on the decedent to support them, and shifting the
20 burden to the larger community. For example, Lewis a
21 34-year-old father to four children was diagnosed
22 with acute Leukemia, with a standard of care is stem
23 cell transplant. After months of intense advocacy we
24 were able to get him insured but unfortunately he
25 relapsed. His family ultimately had to apply for

2 public assistance because they had no other way of
3 getting by. Cases like this have a profound impact on
4 healthcare providers. A study found that providing
5 undocumented patients with sub-optimal care because
6 of their immigration status contributes professional
7 burnout and moral distress. Many of the oncologists
8 I work with reference their experience with
9 undocumented patients as one of the reasons why they
10 are leaving the public health system. As one doctor
11 told me, I love that at Bellevue I can truly practice
12 medicine, but what's the point if I can't even treat
13 some of my patients. [bell] While Bellevue may be
14 the largest safety net hospital in New York City, we
15 have seen similar frustrations and feelings of
16 helplessness across all medical disciplines in both
17 public and private hospitals. Ultimately, a
18 transplant for Lewis and those like him is more cost-
19 effective than continuing futile Chemotherapy and
20 end-of-life care. Cost benefits studies comparing
21 for example stem cell transplants versus chemo,
22 kidney transplants verse dialysis consistently show
23 major direct medial savings as well as adjusted
24 quality of life. Just to finish up, additionally,
25 there's a missed opportunity by denying these

2 patients access to clinical trials, which impact
3 health innovation and quality care for the rest of
4 the population. For two patients that we've worked
5 with Miguel who was diagnosed with stage 4 Melanoma
6 and participated in a ground breaking trial on muna
7 therapy for the treatment of previously untreatable
8 melanoma is now in remission despite initially in
9 being only given a month to live. For others like
10 Vivian she's the only woman of color currently
11 enrolled in a national innovative health trial
12 comparing different forms of stem cell sources for
13 those who cannot find donor matches. These are the
14 exceptions. They were able to participate in these
15 trials and receive these treatments because they were
16 fortunate enough to have a team of doctors and
17 lawyers working together for months. Many patients
18 do not have that luxury or the time to wait. This
19 proposed resolution will help minimize the health
20 inequalities faced by our immigrant population.
21 Thank you.
22 CHAIRPERSON LEVINE: Thank you very much.
23 We are keeping the crowds at bay as long as we can,
24 an you're going to close us out.
25

2 SASFIRS EFMAN Good afternoon. My name
3 is Sasfir Efman (sp?) and I'm a Policy Coordinator at
4 the Coalition for Asian American Children and
5 Families. I want to thank you Council Member Rivera
6 and Council Member Levine for holding this important
7 hearing today. Since 1986 AACF is the nation's only
8 Pan Asian children and families advocacy organization
9 was waged the fight for improved and equitable
10 policies, systems, funding and services to support
11 those in need. The Asian Pacific American APA's
12 population is over 1.3 million people of very rapidly
13 growing communities yet the needs are consistently
14 overlooked, misunderstood and uncounted. Also as a
15 New York State Patient Navigator Contractor that
16 works with eight other APAs serving in that
17 organization, we are too, aware of the challenges APA
18 families and individuals face in accessing adequate
19 health coverage and care. The disparities in health
20 access and care are especially compounded in our
21 community by poverty, immigration status related
22 challenges, language barriers, cultural stigmas
23 regard public benefits and low utilization of primary
24 and preventive care. Consider almost 15% of Asian-
25 Americans ages 18 and over remain uninsured in New

2 York City, and the majority almost 90% of Asian-
3 Americans uninsured are foreign born. 21% o APAs are
4 considered under-insured meaning the insurance
5 coverage that they have is inadequate. And because of
6 the pressing need to ensure better coverage in care
7 for our immigrant community we support the adoption
8 of the two legislations. Introduction—Intro 1668
9 because NYC Care needs to be fully resourced to
10 support the work necessary to ensure that everyone
11 especially the most marginalized and vulnerable
12 communities have access to quality healthcare and
13 coverage. We also advocate for strong partnerships
14 with the local community-based organizations
15 particularly in the APA community to ensure that
16 immigrant communities are being reached [bell] and
17 increase their access, and we do support Resolution
18 098 because of the expansion of health insurance
19 coverage to include those who are ineligible because
20 of their immigration status. Considering that APA
21 families and individuals face high rates of
22 uninsurance and under-insurance on our heavily
23 immigrants this expansion is crucial to improving
24 their overall health and wellbeing. Thank you so
25 much.

2 CHAIRPERSON LEVINE: Thank you very much.
3 We have had 35 people testify and by my tally we've
4 had 35 people who support this legislation and I will
5 just run the numbers here. 0 against. What a
6 fabulous, fabulous hearing this has been, and I think
7 it pushed us forward towards our goal of ensuring
8 that every single person in the city regardless of
9 where they live or what their immigration status is
10 has access to primary care and Chair Rivera, it has
11 been a pleasure as always to leave this with you, and
12 that concludes the hearing. Thank you. [gavel]
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C E R T I F I C A T E

World Wide Dictation certifies that the foregoing transcript is a true and accurate record of the proceedings. We further certify that there is no relation to any of the parties to this action by blood or marriage, and that there is interest in the outcome of this matter.

Date November 6, 2019