



Empire Justice Center

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New York State Legislature 2017-2018 Joint Budget Hearing: Health/Medicaid

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Introduction

My name is Amy Lowenstein and I am a Senior Attorney in the Albany office of Empire Justice Center. I would like to thank you for the opportunity to testify today concerning the 2017-2018 Health and Medicaid Budget.

Empire Justice Center is a statewide legal services organization with offices in Albany, Rochester, Westchester and Central Islip (Long Island). Empire Justice provides support and training to legal services and other community based organizations, undertakes policy research and analysis, and engages in legislative and administrative advocacy. We also represent low income individuals, as well as classes of New Yorkers, in a wide range of poverty law areas including health, public assistance, domestic violence, and SSI/SSD benefits.

Empire Justice has had the opportunity to serve on numerous advisory committees for New York State during Medicaid Redesign and the implementation of the Affordable Care Act. We had an advisory role as a member of the Finger Lakes Regional Advisory Committee for the Health Benefit Exchange and the statewide Medicaid Managed Care Advisory Review Committee. We have also worked directly with the New York State Department of Health, serving on workgroups concerning the Basic Health Program, Managed Long-Term Care quality incentives, Managed Long-Term Care implementation, and Value Based Payment. We serve on the steering committees of Health Care for All New York (HCFANY), Medicaid Matters New York (MMNY), and the Coalition to Protect the Rights of New York's Dually Eligible. We co-facilitate MMNY and HCFANY's Public Programs Group, which meets regularly with the Department of Health on Exchange implementation issues. These experiences, along with our day-to-day work with low income New Yorkers and their advocates, have helped shape the perspective we provide today.

Through my testimony today, Empire Justice Center urges the Legislature to:

1. Expand and strengthen post-enrollment health insurance advocacy and assistance for New Yorkers by supporting the Governor's appropriation for Community Health Advocates (CHA) with an additional legislative investment of \$2.25 million.
2. Keep health care affordable for Essential Plan enrollees by preventing expansion of premiums and annual premium increases and limiting cost sharing.
3. Ensure that sick and disabled children, New Yorkers with disabilities, and seniors continue to have access to medically necessary care by preserving spousal and parental refusal in the Medicaid program.
4. Address barriers to accessing homecare and other community based long term care by taking steps to deal with the Medicaid personal care aide shortage and increase oversight and accountability of Medicaid managed care plans, including MLTC.
5. Ensure that MLTC eligibility rules do not create additional barriers to homecare.

6. Restore access to medically necessary physical, occupational and speech therapies by repealing Medicaid's 20 visit hard cap on those services.
7. Ensure that New York's most vulnerable Medicaid recipients are able to access the medications prescribed by their doctors by preserving prescriber prevails in Medicaid's fee-for-service and managed care programs.
8. Retain the current Medicaid pharmacy copay levels.
9. Preserve the Medicaid hospice benefit.
10. Preserve Medicaid bed hold payments to nursing homes so that residents who are temporarily hospitalized or on other therapeutic leave, such as to briefly visit a family member, may return to the same nursing home.
11. Raise the Child Health Plus age limit to 30 so that all young adult New Yorkers, regardless of immigration status, can access health insurance.
12. Ensure that the Health Care Regulation Modernization Team has substantial voting representation from Medicaid consumers and organizations that represent consumers' interests, and that the powers of the Modernization Team are limited to an advisory role and do not bypass procedures required to suspend regulations and laws.

Support Community Health Advocates (CHA)

Recommendation: Provide a legislative add of \$2.25 million for a total investment of \$4.75 million for Community Health Advocates (CHA).

Since November 2010, the Community Health Advocates (CHA) program has handled more than 281,000 cases, helping individuals understand, navigate and keep their health coverage, and access health care. CHA's services range from helping people understand how to use their health insurance to handling complex health care denial appeals and resolving medical debt. Since its inception, CHA has saved New Yorkers across the state more than \$21 million in health related and health insurance costs. CHA provides critical assistance to all New Yorkers, regardless of insured status or insurance coverage type, including commercial insurance available through the Marketplace, employer coverage, and public insurance products like Medicaid and Child Health Plus.

We appreciate the Governor's continued support for CHA through the \$2.5 million allocation in the Executive Budget. However, we are asking the Legislature once again to provide additional funds to restore last year's level and provide enhanced funding for a total of \$4.75 million. This will allow programs to address growing fear and concerns raised by New Yorkers as a result of potential changes to health insurance programs at the federal level.

CHA consists of a statewide network of 25 community based organizations, including chambers of commerce, and three specialist agencies, as well as a live-answer, toll-free consumer helpline. CHA also supports efforts to improve the health care system by analyzing trends in its statewide database and providing valuable feedback to policy makers.

The health care system is notoriously challenging to navigate. Most consumers have difficulty grasping even basic terms associated with health insurance coverage such as deductibles, co-insurance and co-pays. Understanding how to utilize health insurance coverage to access care, particularly when insurers place restrictions on that care, is even more difficult. With shifting health care priorities at the federal level, CHA is needed more than ever to help guide consumers through the changing health care landscape and make sure they are able to access and understand any new programs or changes to existing programs as they emerge.

This year, Empire Justice Center and our colleagues are asking both houses of the Legislature to increase support for CHA to \$2.25 million, building on the \$2.5 million in the Executive Budget, for a total investment of \$4.75 million. This level of legislative investment will allow CHA to deepen its presence in communities across the state through expansion of its network of community based organizations, and allow CHA to assist health care consumers in adjusting to the current uncertainty about how their health care may change, and to help consumers navigate any changes that come to fruition.

More information on CHA is available online at www.communityhealthadvocates.org.

Keep Health Care Affordable for Low Income New Yorkers

Recommendations: Oppose proposals that would require lower income New Yorkers to pay a premium for the Essential Plan and to increase the premium amount every year. Create legislative limits on cost sharing in the Essential Plan.

One year into its launch, New York's Essential Plan (EP) has been a tremendous success in making health insurance much more affordable for people who are just above the Medicaid income eligibility threshold. With more than 640,000 enrollees, the program is making an enormous difference to low income New Yorkers who, even with federal subsidies and cost sharing assistance, previously could not afford health insurance.

The success of the Essential Plan is likely attributable to its affordability. Nevertheless, the Governor now proposes to increase the cost burden on low income families enrolled in the Essential Plan by requiring them to pay a \$20 premium for access to healthcare; increasing the premium for the Essential Plan by the medical consumer price index every year; and increasing cost sharing, including copayments, that Essential Plan enrollees must pay to obtain health care.

While Essential Plan enrollees are not Medicaid beneficiaries, it is instructive that Medicaid prohibits charging premiums to Medicaid recipients with incomes at or below 150% of the

federal poverty level.¹ Yet the Governor proposes to do just that with New Yorkers equally unable to afford premiums -- Essential Plan enrollees with incomes between 138-150% of the federal poverty level.

Studies have shown that health insurance premiums are a significant barrier to low income individuals enrolling in and keeping coverage, and that cost sharing impedes low income individuals' access to care, resulting in foregoing effective and essential care.² Moreover, the medical consumer price index rises faster than wages. As a result, even those individuals currently paying a \$20 premium for the Essential Plan will find themselves increasingly unable to afford the increased costs.

The legislature should reject the proposal to require low income individuals to pay a premium for the Essential Plan and the proposal to annually increase Essential Plan premiums. Additionally, the legislature should set statutory limits on any cost sharing that Essential Plan enrollees may be charged.

Preserve Spousal and Parental Refusal

Recommendation: Oppose the proposed elimination of the spousal and parental refusal option for low income Medicaid applicants and recipients.

We strongly oppose the Executive Budget's wholesale elimination of the spousal and parental refusal provisions currently available to help children and adults with disabilities and seniors access medically necessary Medicaid, as well as Medicare services that would otherwise be unavailable or unaffordable to them due to a spouse's or parent's income.

The Executive Budget would eliminate the longstanding right to utilize spousal refusal for community Medicaid eligibility, and would also abolish parental refusal which allows severely disabled children to access Medicaid. Under the Governor's proposal, "refusal" will only be allowed if a parent lives apart from a sick or disabled child, or a well spouse either lives apart from or divorces the spouse in need of Medicaid coverage. Seriously ill children will lose access to Medicaid under this provision, and low income seniors and people with disabilities will lose access to both Medicaid and the ability to obtain assistance with Medicare cost-sharing expenses. While the Affordable Care Act now makes access to affordable care more feasible, many of New York's most vulnerable residents are not eligible for Marketplace coverage, or the coverage is insufficient to meet their medical needs. These individuals will be left without access to vital Medicaid services, like homecare, should the legislature adopt the proposal to restrict the right of spousal or parental refusal.

¹ 42 C.F.R. § 447.55.

² Michael Hendyx et al., "Effects of a Cost-Sharing Policy on Disenrollment from a State Health Insurance Program." *Social Work in Public Health*; Vol. 27 (No. 7): 671-686, 2012; Laura Snyder & Robin Rubowitz, "Premiums and Cost-Sharing in Medicaid: A Review of Research Findings." Kaiser Commission on Medicaid and the Uninsured, 2013.

Situations continue to arise where parental or spousal refusal is necessary to ensure access to medical care. For example, we advised spousal refusal for a woman with multiple chronic health and mental health conditions, who was on Social Security Disability and trying to afford hundreds of dollars' worth of drug copays every month through her spouse's employer insurance, and would have faced similarly unaffordable drug costs in a Medicare Part D plan. When she reached out to us for assistance, she was concerned she would have to forego some of her needed medication. With a spousal refusal, she was able to get on the Medicare Savings Program and, thereby, get Extra Help paying for her Part D drugs, making prohibitively expensive drugs affordable and allowing her to receive appropriate treatment for her medical conditions.

Almost always, individuals who end up using spousal and parental refusals are in desperate straits when they contact us – they have no Medicare Part B coverage at all, cannot afford their drug co-pays, need homecare in order to avoid nursing home placement, or have significant disabilities and can't access the medical care they or their children need. Spousal or parental refusal affords these individuals a vital lifeline to obtain and retain necessary medical coverage and services. Empire Justice Center therefore strongly opposes the Governor's proposal to limit spousal and parental refusal and urges the Legislature to reject it as it has, thankfully, done in the past.

Make “Community Integration for Every New Yorker” a Reality

Recommendation: Address the Medicaid personal care aide and consumer directed personal assistant shortage, and increase oversight and accountability of Medicaid managed care plans, including Managed Long Term Care plans.

At a time when New York State has expressed its commitment to the goal of “community integration for every New Yorker,”³ it is critical that the community-based long term services and supports, including homecare, necessary to make this goal a reality are widely available and provided.

Most people who need community based long term care must obtain those services from mainstream Medicaid Managed Care or Managed Long Term Care (MLTC). Unfortunately, many individuals are not receiving the services they need to stay in their homes or to leave institutional settings such as nursing homes. The barriers to accessing services are manifold, and include:

- A shortage, particularly upstate, of personal care aides, consumer directed personal assistants, and home health aides. The upstate aide shortage has reached crisis levels, leaving individuals in need of homecare stuck in nursing homes, unnecessarily hospitalized, or putting their health and safety at risk at home without sufficient aide services. We have repeatedly heard from advocates and individuals that local districts and managed care plans are not able to fill approved hours because there are no aides available in a rural area, or because an enrollee does not live on a bus line.

³ <https://www.ny.gov/programs/olmstead-community-integration-every-new-yorker>.

Now that aides are finally covered by the Fair Labor Standards Act's overtime and travel requirements, the aide shortage has intensified. Personal care providers as well as some fiscal intermediaries are capping aide hours to avoid the requirements, resulting in further reduction of the available workforce.

- Managed care plans are discouraging people with higher needs from enrolling in their plans by offering hours that are insufficient to allow an individual to live at home, impermissibly requiring people to have a family caregiver as “backup” support, telling people their needs are too high before conducting an assessment, and telling people who may need 24-hour care that they do not provide that level of care.
- Widespread reductions in personal care service hours by managed care organizations are occurring. Almost always the justifications for these reductions are legally insufficient and, if taken to a hearing, the Medicaid recipient prevails ninety percent of the time.⁴ However, the cuts in hours continue, presumably in the hope that many enrollees will not bother to appeal or will agree to negotiate for a smaller reduction in hours, but fewer hours than they would win at a hearing.
- Some managed care companies are actually refusing to comply with fair hearing decisions.

We understand the challenge in finding solutions to these and other barriers to accessing community based services. With that in mind, we urge the following:

- Strengthen the community-based long term care workforce and address the workforce shortage by ensuring adequate competitive wages and benefits for home health aides, personal care assistants and consumer directed personal assistants.
- Provide the necessary funding to pay competitive wages to aides as well as to pay for overtime and travel requirements. This includes providing managed care capitation rates that are sufficient to account for increased costs and requiring that any increased capitation rate be used to increase the availability of aide services. It also requires ensuring that the counties, which are still responsible for providing aide services to Medicaid waiver participants and people excluded from managed care and ineligible for managed long term care, are able to offer competitive reimbursement rates to home care agencies. Currently counties cannot compete with the rates offered by managed care even as the managed care rates are insufficient to attract sufficient numbers of aides.
- Incentivize managed care plans to enroll and serve individuals with high needs by creating a high needs community rate cell for managed long term care.
- Improve oversight and accountability of managed care plans. This should include requiring plans to report any homecare hour reductions, including the previously authorized amount, the reduced amount and the reason for reduction, so that the Department of Health can identify patterns of reductions. It should also include

⁴ Medicaid Matters New York & National Academy of Elder Law Attorneys, NY Chapter, “Mis-Managed Care,” Jul. 2016, available at <http://medicaidmattersny.org/cms/wp-content/uploads/2016/08/Managed-Long-Term-Care-Fair-Hearing-Monitoring-Project-2016-07-14-Final.pdf>.

reporting of new permanent placement in nursing homes, along with data on the number of hours of homecare previously received by the new nursing home resident, if any, the reason for permanent placement, and an explanation of why services are not being provided to the individual in a community setting. Analyses of the number of home care hours and individuals in nursing homes should be made publicly available. In addition, the Department of Health should annually publish detailed managed care plan-specific data on plan grievances, internal appeals, external appeals, complaints to the Department of Health, and fair hearings. This would be consistent with what the Department of Financial Services does with commercial insurance plans (see, for example, http://www.dfs.ny.gov/consumer/health/cg_health_2016.pdf).

Oppose Changes in MLTC Eligibility Requirements That Will Create Additional Barriers to Care

Recommendation: Oppose the Governor’s proposal to require that individuals dually eligible for Medicare and Medicaid meet a “nursing home level of care” in order to receive long term community based services.

Empire Justice Center opposes the Governor’s proposal to add a nursing home level of care requirement as a condition of eligibility for Managed Long Term Care (MLTC). While there have been notable challenges in accessing care through MLTC, we have a number of grave concerns about the proposal.

First, those who will no longer be eligible for MLTC under the proposal will have even more difficulty accessing the home care services they require.

By adding a nursing home level of care requirement, the Executive Budget clearly anticipates that additional individuals who are currently MLTC eligible no longer will be. All of these individuals will be dual eligibles (people on Medicaid and Medicare) who require more than 120 days of long term level II personal care services, but who do not have a nursing home level of care. While the Governor’s Budget Memo states that individuals excluded from MLTC under the proposal “would still receive comparable services from a managed care plan,” this is not the case. Dually eligible people are excluded from enrolling in mainstream managed care plans and, therefore, if also excluded from MLTC, must receive services from county Departments of Social Services. Medicaid only recipients – those not on Medicare – would not be affected by the proposal as they already are required to need a nursing home level of care to enroll in MLTC instead of mainstream managed care.⁵

The duty to provide services to the population that will no longer be MLTC eligible will fall to the Local Departments of Social Services. But those departments do not have the capacity to serve these higher need individuals, let alone the individuals for whom they are currently responsible. With the roll out of mandatory MLTC statewide now complete, many

⁵ MLTC Policy 14.01, available at https://www.health.ny.gov/health_care/medicaid/redesign/mltc_policy_14-01.htm.

Departments of Social Services have severely reduced resources available in their home care programs, and already struggle to provide services to those for whom they still retain responsibility.⁶ At least one county has noted that it no longer has nurses to assess people for personal care, allegedly because providers are no longer willing to take the low reimbursement rate when better rates are available from MLTCs. As of this past summer, another county acknowledged having a waiting list of over 100 Medicaid beneficiaries in need of personal care services. And still another county had been requiring consumers to sign waivers acknowledging an aide shortage prior to receiving services.

Because the already under-resourced Departments of Social Service would be picking up a higher and more complex homecare caseload without being provided additional resources to serve this new population, as well as existing populations, the Governor's proposal should be opposed.

Second, the proposal will result in MLTCs serving a population with higher needs overall. Those dual eligibles currently in MLTC who do not have a nursing home level of care are presumably the MLTC members with the lowest needs. In order for MLTC to be a viable model for providing community-based long term care, the plans must have a mix of members with various levels of needs ranging from low to high, distributed roughly along a bell curve. This allows plans to serve its higher need members by spreading the cost of their care out to a larger number of lower need members. If the lowest need individuals are cut out of MLTC, the overall needs of the population served by MLTC will be higher – essentially creating a high needs insurance plan. We do not believe MLTCs, many of which already struggle to serve high need members, will be able to adjust to this shift without reducing the hours they provide to their higher need members and further limiting the number of high need individuals they are willing to accept. This will leave people with disabilities that are most in need of home care at substantial risk of having insufficient or no care, and being forced into an institutional setting in order to survive. Already this past year, two large MLTCs left or expressed their intention to leave MLTC, including Guildnet, whose CEO informed the Department of Health that the “calamitous state of reimbursement” made it no longer feasible to operate because the program was incurring “substantial deficits.”⁷

Third, the population that will no longer be eligible for MLTC under the proposal will lose an important benefit of MLTC: the availability of spousal impoverishment budgeting for married couples. Outside of MLTC and the waiver programs, a couple with a spouse in need of home care must spend down their joint income to below the federal poverty level and spend down their assets in order to obtain services through Medicaid. MLTC, however, allows couples to use spousal impoverishment protections, allowing the spouse in need of care to get that care

⁶ Local Departments of Social Services are still responsible for providing services to (1) dual eligibles who need only Level I personal care, a.k.a., housekeeping; (2) dual eligible who need less than 120 days of any type of “long term care service,” such as personal care, home health aides, or nursing; (3) certain Medicaid waiver participants; (4) those who are exempt from managed care like people with third party health insurance other than Medicare.

⁷ Dan Goldberg, “Medicaid care plan pulling out of 3 counties because of ‘calamitous’ reimbursement,” Politico, Nov. 23, 2016, available at <http://www.politico.com/states/new-york/albany/story/2016/11/guildnet-cant-pulling-out-of-some-counties-because-of-calamitous-reimbursement-107541>.

while making sure that the family is not impoverished in the process. Without spousal impoverishment protections, couples excluded from MLTC may find themselves having to choose divorce or poverty in order to ensure that needed care is available.

Remove Medicaid Physical, Occupational & Speech Therapy Visit Caps

Recommendation: End the 20 visit hard cap on physical, occupational and speech therapy in the Medicaid program by repealing New York Social Services Law § 365-a(2)(h).

For the past five years, the 20 visit cap on physical, occupational, and speech therapy in the Medicaid program has resulted in denial after denial of medically necessary therapies. It has left Medicaid recipients with disabilities unable to maintain functioning they had, left victims of accidents in pain and without the means to regain full functioning, left individuals without the ability to restore functioning after surgery, and prevented people from being able to return to work. It is time for New York to remove the therapies cap, which has no medical necessity exception, through repeal of New York Social Services Law § 365-a(2)(h).

The physical, occupational, and speech therapy caps are blocking access to medically necessary treatment and causing real harm to New Yorkers. For example, in the past year:

- A New York City woman was denied physical therapy following a hip replacement because she had previously used 20 visits. The administrative law judge noted that even when physical therapy is medically necessary, Medicaid does not cover more than 20 visits a year.⁸
- A 49 year old New York City woman had a torn rotator cuff. At her physician's recommendation, she tried injections and physical therapy to try to relieve symptoms associated with the injury. When she did not receive relief, she underwent shoulder repair surgery after which she received physical therapy. Her request for additional physical therapy to treat post-operative stiffness and limited range of motion were denied despite letters from two of her doctors regarding the medical necessity of the therapies and the administrative law judge's finding that the woman's testimony was "persuasive and sympathetic."⁹
- An Albany woman received only two physical therapy sessions after knee surgery because she had used up the rest of her allotment of physical therapy treating her ankle earlier that year.¹⁰

⁸ Decision After Fair Hearing, FH# 7338295P, Aug. 29, 2016, available at http://otda.ny.gov/fair%20hearing%20images/2016-8/Redacted_7338295P.pdf.

⁹ Decision After Fair Hearing, FH# 7318664Z, Aug. 2, 2016. Available at http://otda.ny.gov/fair%20hearing%20images/2016-8/Redacted_7318664Z.pdf

¹⁰ Decision After Fair Hearing, FH# 7299981Y, Jun. 24, 2016 http://otda.ny.gov/fair%20hearing%20images/2016-6/Redacted_7299981Y.pdf

- A 34 year old New York City man was denied the additional physical therapy needed after knee surgery to gain the mobility he required to return to work and avoid an additional invasive surgery.¹¹
- A Monroe County man had been receiving physical therapy, but when his symptoms were not resolved, he underwent surgery. He was denied all but one post-operative physical therapy session that he needed to maximize recovery and prevent permanent damage. Because he had not recovered from the surgery he was not able to return to his job. While upholding the denial of physical therapy, the administrative law judge advised the man to consult with a physician again at the end of the year to get a new physical therapy prescription.¹²

The above are just a handful of examples of the absurd consequences New York Medicaid's 20 visit physical, occupational, and speech therapy limit is having. Had any of these individuals been on Medicare or in the Essential Plan or a qualified health plan (QHP), they would have had the opportunity to obtain their medically necessary treatment instead of having their treatment options foreclosed because of an arbitrary cap.

Medicare places an annual dollar limit on the three therapies, but, critically, provides for an exceptions process that allows coverage beyond the dollar limit where additional therapies are medically necessary.¹³

As part of the required essential health benefits in New York, small group and individual health insurance plans, including QHPs and the Essential Plan, currently have a 60 visit per year cap on rehabilitative physical, occupational, and speech therapies, and an additional 60 visits per year habilitative services benefit for the three therapies.¹⁴ Habilitative services include therapies to maintain or prevent deterioration in functioning. Notably, of the ten group insurance plans New York looked at when considering what plan would serve as its 2017 base benchmark plan, only one used a 20 visit per year limit.¹⁵

New York's Medicaid's physical, occupational, and speech therapy caps are completely out of step with what is happening in commercial insurance and in Medicare. And yet many Medicaid recipients are sicker and more disabled than their counterparts in commercial plans. The Medicaid program should no longer seek savings at the expense of individuals' ability to

¹¹ Decision After Fair Hearing, FH# 7282819M, May 13, 2016, available at http://otda.ny.gov/fair%20hearing%20images/2016-5/Redacted_7282819M.pdf.

¹² Decision After Fair Hearing, FH# 7417933N, Dec. 13, 2016, available at http://otda.ny.gov/fair%20hearing%20images/2016-12/Redacted_7417933N.pdf.

¹³ 42 U.S.C. § 1396r-5l(g).

¹⁴ New York 2017 EHB Benchmark Plan, p. 3. Available at <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/NY-BMP.zip>.

¹⁵ Two plans had no cap, one had a 70 visit per year cap, four had 60 visit per year caps, one had a 50 visit per year cap, and one had a 30 or 20 year cap depending on the therapy. New York's Essential Health Benefit Base Benchmark Options Effective January 1, 2017, p. 5. Available at http://info.nystateofhealth.ny.gov/sites/default/files/New%20York%E2%80%99s%20Essential%20Health%20Benefit%20Base%20Benchmark%20Options_0.pdf.

avoid pain, recover from surgery, prevent physical decline, and return to work. The Legislature should repeal the therapy caps and in doing so restore Medicaid recipients' ability to maintain and improve their functioning so that they can participate to their maximum capacity in daily life.

Retain Prescriber Prevails

Recommendation: Preserve prescriber prevails in the Medicaid fee-for-service and managed care programs.

Empire Justice Center opposes the Governor's proposed elimination from the Medicaid fee-for-service and managed care programs of important prescriber prevails protections for prescription medications other than atypical antipsychotics and antidepressants. Eliminating prescriber prevails would create new barriers to individuals obtaining medications prescribed by their doctors, including medications on which they have been stabilized.

Because of their familiarity with their patients' medical and clinical histories, health care providers are in the best position to know which medications and combinations of medications are most appropriate and safest for their patients. This is particularly true when it comes to patients with complex needs, chronic illness, and co-occurring disorders. Providers who treat these patients must make prescribing decisions that take into consideration not only the condition for which a drug is used, but also interactions with multiple drugs and how a drug's effects, including side effects, may impact co-occurring conditions.

Doctors with intimate knowledge of their patients' diagnoses and other medications should have final say over what medications are necessary and appropriate for their patients, and New York State should not seek to save money by eliminating protections for the most medically needy New Yorkers.

Protect Medicaid Recipients from Increased Drug Costs

Recommendation: Oppose increases in drug costs for Medicaid beneficiaries.

The Executive budget proposes that the price Medicaid beneficiaries pay for preferred prescription drugs increase by 150% (from \$1 to \$2.50) and over-the-counter medication double (from 50 cents to \$1). These costs might seem insignificant to some, but for low income Medicaid beneficiaries who take multiple medications to manage their illnesses, these costs can add up fast. And even moderate increases in copayments can lead to low income individuals foregoing care.¹⁶ Although Medicaid beneficiaries who cannot afford copays

¹⁶ Michael T. Eaddy et al., "How Patient Cost-Sharing Trends Affect Adherence and Outcomes: A Literature Review," *Pharmacy & Therapeutics*, 37(1): 45-55 (January 2012), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3278192/>; Laura Snyder & Robin Rubowitz, "Premiums and Cost-Sharing in Medicaid: A Review of Research Findings." Kaiser Commission on Medicaid and the Uninsured (2013).

cannot be denied access to their medications, many consumers as well as pharmacists are unaware of this protection, and the Medicaid beneficiary still owes the debt for the unpaid copays. This proposal will only serve to restrict access to needed medication and add to the debt burden of low-income New Yorkers.

Preserve the Medicaid Hospice Benefit

Recommendation: Oppose the proposed statutory language changes to the Medicaid hospice benefit.

For people with a terminal illness, hospice provides needed care, comfort and support. The Governor's budget proposal would reduce access to this critical end of life care.

While the Memorandum in Support of the Health and Mental Hygiene Article VII language states that the proposed amendment to the Social Services Law regarding hospice is intended to "clarify that Medicaid would not cover hospice-related services otherwise covered by Medicare," the proposed amendment does not remotely accomplish this goal. Instead, depending on how the proposed language is interpreted, the amendment would do one of two things to restrict access to hospice services in Medicaid:

- (1) Limit the Medicaid hospice benefit to dual eligibles, meaning Medicaid-only recipients would no longer get hospice services at all; or
- (2) Limit the Medicaid hospice benefit to the exact scope of what Medicare covers. Since a person must have a life expectancy of six months or less to be eligible for Medicare covered hospice,¹⁷ but may have a life expectancy of 12 months or less to obtain Medicaid covered hospice,¹⁸ the proposal would further limit Medicaid beneficiaries' access to hospice services.

The proposed language not only restricts the Medicaid hospice benefit while not accomplishing what it purports to, but there is no statutory amendment required for the Department of Health to realize its goal of ensuring that Medicaid does not pay for Medicare covered hospice services. Under federal and New York law, Medicaid is already the payer of last resort and Medicaid providers are required to bill third parties, including Medicare, prior to billing Medicaid.¹⁹ Moreover, through the Medicaid Inspector General, the State has the authority, which it has used, to seek recoupment of Medicaid payments when Medicare was not billed first.²⁰

¹⁷ 42 C.F.R. §§ 418.20(b), 418.22(b)(1).

¹⁸ New York State Medicaid Plan, Plan Amendment 11-89, approved effective April 1, 2012. Available at <https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/NY/2014/NY-11-89.pdf>.

¹⁹ 42 U.S.C. § 1396a(25); 8 N.Y.C.R.R. § 540.6(e).

²⁰ N.Y. Pub. Health L. § 32(22).

Preserve Bed Hold Payments for Nursing Home Care

Recommendation: Preserve Medicaid bed hold payments to nursing homes so that residents who are temporarily hospitalized or on other therapeutic leave, such as to briefly visit a family member, may return to the same nursing home.

The Governor proposes to eliminate Medicaid payment to nursing homes to hold beds for a resident who is temporarily hospitalized or goes on other therapeutic leave, such as to briefly visit a family member or attend a funeral. While the Governor's Budget Memo claims that the proposal would "preserve the requirement for nursing homes to hold beds for residents who temporary leave a nursing home," it is not evident where in New York State or federal law the requirement to hold beds, absent payment, is actually preserved. Moreover, even if there is a requirement that nursing homes hold beds without payment for a certain amount of time, there is concern that these bed holds will not be honored.

Under current New York State law and regulation, nursing homes with a vacancy rate of 5% or under are paid by Medicaid to reserve a resident's bed during a brief hospital stay or leave of absence. The Governor's proposal would end bed hold payments, and possibly bed holds entirely, regardless of how low the vacancy rate in the nursing home is, regardless of whether the resident lived in the nursing home for 30 days or five years, and regardless of the emergent nature of a hospitalization or however brief.

Eliminating bed hold payments will erode the right of nursing home residents to return to the same nursing home and to their own room, if available. The Department of Health has had to remind nursing homes of their obligation to re-admit residents after a hospital stay even without a bed hold, if a bed is available. In a 2015 letter to nursing home administrators, the Department expressed "concern regarding provider trends related to resident transfer and discharge, including ... [the] [r]efusal to readmit nursing home residents who are temporarily hospitalized."²¹ If the Department of Health observed trends in nursing homes failing to re-admit residents even when they were paid by Medicaid to hold a bed, we can expect an uptick in this trend when nursing homes are expected to keep a bed available without any payment at all. People with cognitive or mental impairments are particularly vulnerable to being illegally barred from readmission by nursing homes. So common was this problem of nursing homes refusing to readmit this particular population of residents that the Department reminded nursing homes:

When sending residents with episodes of acting out behavior to hospitals for treatment, the nursing home is responsible to readmit the resident and/or develop an appropriate discharge plan. In these cases, the hospital is not considered to be the final discharge location.²²

²¹ DAL NH 15-06 - Transfer & Discharge Requirements for Nursing Homes (Sep. 23, 2015), available at https://www.health.ny.gov/professionals/nursing_home_administrator/dal_nh_15-06_transfer_and_discharge_nh_requirements.htm.

²² *Id.*

Expand Child Health Plus to Young Adults Under 30

Recommendation: Raise the age limit for Child Health Plus to 30, thereby allowing all young adult New Yorkers, including DREAMers, to be able to access health insurance.

Currently, Child Health Plus (CHIP) provides affordable health coverage to anyone below the age of 19 who resides in New York State. This coverage is available regardless of immigration status. Families pay premiums on a sliding scale. Expanding the age limit for CHIP to include young adults under age 30 will allow New York State to continue the coverage gains of the past few years.

In 2016, the Community Service Society examined this proposal in the context of providing coverage for people who are not eligible for Medicaid, the Essential Plan, or subsidized Qualified Health Plans because of their immigration status, including many young adult immigrant “DREAMers.” That analysis found that raising the upper age limit of CHIP would make an additional 90,000 people eligible for subsidized health coverage. Based on previous enrollment rates, it would likely result in extending health coverage to 27,900 young adult immigrants at a cost of \$78 million, an increase of less than one percent of New York’s health budget. The updated costs of this proposal for 2017 would be \$81 million.

The benefits of increased coverage for both the young adults gaining coverage and society at large are well-documented. People without insurance coverage are more likely than their insured counterparts to delay seeking care, incur medical debt or file for bankruptcy, and experience high rates of morbidity and mortality because of their inability to access preventive care or services needed to manage serious and chronic health conditions. It is inevitable that some people without coverage will fall ill or need health services. When this happens, the losses experienced by the health care system are offset through higher prices for everyone.

Revise the Composition of and Limit the Powers of the Health Care Regulation Modernization Team

Recommendation: Ensure that the Health Care Regulation Modernization Team has substantial voting representation from Medicaid consumers and organizations that represent consumers’ interests, and that the powers of the Modernization Team are limited to an advisory role and do not bypass procedures required to suspend regulations and laws.

The Governor proposes the creation of a Health Care Regulation Modernization Team “to create a more efficient healthcare system” and respond to ongoing health care reform and changes to where services are delivered. Empire Justice Center agrees that there is a need to review New York’s health care regulations, particularly those that create barriers to care, and that stakeholder input into the review process is important.

Nevertheless, the Modernization Team proposal fails to ensure sufficient representation by consumers and groups representing consumer interests. Not one of the 25 voting members of the Modernization Team is reserved for a group representing health care consumer interests. Empire Justice Center believes that at least 20% of the voting members of the group should be filled by health care consumers or organizations that represent the interests of health care consumers. These voting members should include representatives from groups that serve different parts of the state and have expertise in health related issues affecting Medicaid beneficiaries and other low-income individuals, the LGBTQ community, people with disabilities, people of color, women, and immigrants. All meetings of the Modernization Team should be public, allowing in-person public attendance as well as live-stream viewing.

We are also deeply concerned about the aspect of the Modernization Team proposal which appears to grant the Team the ability to give the commissioners of health, mental health and the office of alcoholism and substance abuse services unfettered authority to suspend statutes and regulations to run demonstration programs that would otherwise be impermissible. This broad authority should be rejected. Many regulatory and statutory requirements that appear burdensome to some stakeholders are designed to protect others, often consumers. Decisions about temporarily waiving statutory requirements, if ever appropriate, should be left to the legislature after considering specific and concrete demonstration project proposals. And any suspension of regulations should continue to be subject to the State Administrative Procedures Act.

Thank you for the opportunity to submit this testimony. Please feel free to contact me with any questions.

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