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Testimony of The Legal Aid Society
Joint Budget Committee Hearing: Health/Medicaid
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Thank you for the opportunity to testify today in response to the 2018-2019 Executive Budget Proposal on Health/Medicaid. My name is Rebecca Antar Novick and I am the Director of the Health Law Unit at The Legal Aid Society in New York City.

Introduction

The Legal Aid Society is a private, not-for-profit legal services organization, the oldest and largest in the nation, dedicated since 1876 to providing quality legal representation to low-income New Yorkers. It is dedicated to one simple but powerful belief: that no New Yorker should be denied access to justice because of poverty. The Legal Aid Society's Health Law Unit (HLU) provides direct legal services to low-income health care consumers from all five boroughs of New York City. The HLU operates a statewide helpline and assists clients and advocates with a broad range of health-related issues. We also participate in state and federal advocacy efforts on a variety of health law and policy matters.

We are grateful to Governor Andrew Cuomo for proposing a budget that maintains the strength and integrity of New York's Medicaid program, especially in the face of persistent threats from the federal government to Medicaid and the health care system as a whole. The Legal Aid Society applauds the Cuomo Administration for its recognition of the crucial role that Medicaid and other public programs play in supporting and strengthening New York families. We are confident that New York will continue to be a leader in providing high quality comprehensive health care in the Medicaid program.

As New York's Medicaid program continues to implement sweeping changes to programs and products, it is particularly important to protect low-income New Yorkers' access to quality health care benefits and services. We wish to comment on several proposals that we believe could have a significant impact on our clients' health and well-being.

The Budget Must Protect Managed Long Term Care Beneficiaries' Access to Care

The Managed Long Term Care (MLTC) program has experienced significant growth since it became a mandatory program for certain Medicare and Medicaid beneficiaries in 2012. Though we recognize the Administration's concerns about the rising costs of the program, it is essential that changes to the program do not negatively impact access to appropriate care for these particularly vulnerable beneficiaries.

Managed Long Term Care Beneficiaries' Access to Appropriate Services Should Not Be Limited by a Plan Lock-In

The Executive Budget proposes a lock-in period for MLTC beneficiaries in which plan members cannot change their plans more than every 12 months after an initial 30 or 45 grace period (Part B, Section 4). Beneficiaries then will be allowed to change plans only for "good cause" reasons, to be determined by the Commissioner.

Though there is a similar lock-in provision in mainstream managed care, the initial grace period in the mainstream program is 90 days.¹ It would be unreasonable to impose a more stringent lock-in requirement on a population that by definition has more extensive needs. In addition, mainstream beneficiaries who are eligible for Health and Recovery Plans (HARPs) because of a serious behavioral health condition and those who are eligible for Special Needs Plans (SNPs) because they are HIV+, homeless, or transgender are able to switch from a mainstream plan to a HARP or SNP at any time.² This recognition of the importance of providing high needs individuals with flexibility to access appropriate services should be preserved in the MLTC program.

Although MLTC beneficiaries have several dispute resolution options available to them, there are numerous circumstances in which changing to a new plan is the best option for a beneficiary. Unfortunately, we have observed serious information gaps about the services available through plans and the likelihood of getting them. We represented one individual with terminal cancer whose daughter virtually never slept, taking care of her throughout the night in addition to working two day jobs. When the daughter asked her mother's case manager if she could request more hours of care, she was incorrectly told that the 30 weekly hours her mother was receiving was the limit, and was discouraged from even putting in a request.

This client was one of many who, prior to reaching out to us, have been unable even to request additional services from their plans because of misinformation or inadequate case management. Often, beneficiaries in this situation prefer to start over with a different plan rather than continue to advocate with a plan that they believe has betrayed their trust. The right to change plans is particularly important for those who are unrepresented and may be less likely to be successful in a hearing or appeal.

¹ N.Y. State Dep't of Health, Medicaid Managed Care / Family Health Plus / HIV Special Needs Plan / Health and Recovery Plan Model Contract, §7.1, https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf.

² *Id.*

The Long Term Nursing Home Benefit Should Not Be Carved Out of Managed Long Term Care Benefits

Only three years after the long term nursing home benefit was carved into the MLTC program,³ the Executive Budget proposes to disenroll from MLTC any beneficiaries who are in a nursing home for six months (Part B, Section 5). The budget language itself is troubling in that it describes individuals who are in a nursing home for six consecutive months as being “permanently placed.” In fact, The Legal Aid Society frequently represents individuals who can safely live in the community, but who remain in nursing homes for more than six months for a number of reasons including the failure of MLTC plans to authorize appropriate levels of home care to allow them to live at home. Before the nursing home carve-in, the difficulty of leaving a nursing home was exacerbated by the extraordinary difficulty of coordinating the MLTC enrollment process with the transition from nursing home to the community. This complex process involves the coordination of the local district, the enrollment broker, the plan, the nursing home, and often other providers.

This proposal is based on the purported duplication of care management services and costs by the MLTC plan and the nursing home. However, we have observed in many cases a troubling lack of effective care management by both MLTC plans or nursing homes to help people transition from nursing home to the community. If this proposal goes forward, it should be accompanied by robust procedures to ensure that staying in a nursing home for six months does not create significant roadblocks for a return to the community. For example, an attestation from a physician or an enrollee that the enrollee intends to return to the community could allow that individual to remain in MLTC for longer than six months. There must be a seamless process for transitioning prospective MLTC beneficiaries out of nursing homes for which one entity (e.g. the local district) is ultimately responsible.

This proposal is also concerning to the extent that it creates a financial incentive for plans to put high-need beneficiaries in nursing homes. With nursing homes part of the MLTC capitation rate, plans are responsible for the costs of care for high-need beneficiaries regardless of whether they are in the community or an institution. Last year, the Department of Health sent a budget side letter to the Legislature in which it committed to exploring the possibility of both a high-need community rate cell and a nursing home rate cell.⁴ A nursing home carve-out makes a high-need community rate cell even more crucial, as otherwise plans have a significant financial incentive to move high-need beneficiaries into nursing homes, possibly in violation of the Americans with Disabilities Act.

³ N.Y. State Dep’t of Health, “Medicaid Redesign Team – Managed Care Benefit and Population Expansion,” https://www.health.ny.gov/health_care/medicaid/redesign/2017/docs/mc_transitions_timeline.pdf.

⁴ Letter from Jason Helgeson to Assembly Member Gottfried, Apr. 10, 2017, *available at* <http://www.dickgottfried.org/wp-content/uploads/2017/04/Budget-Side-Letter-Assembly-Member-Gottfried.pdf>.

A Requirement of Uniform Assessment System Score of 9 Should Not Be Imposed for MLTC Eligibility

The Executive Budget would also limit MLTC enrollment for certain lower-need beneficiaries, by limiting MLTC eligibility to those with a Uniform Assessment System (UAS) score of 9 or higher (Part B, Section 3). Though we understand that this will impact a relatively small group of individuals, as most MLTC beneficiaries have a UAS score above 9 and current beneficiaries will be grandfathered in, we are concerned that the local districts may not have the capacity to adequately deliver home and community based services to a larger population. In addition, MLTC has provided benefits to people that are not available outside of the program, such as home modifications that allow them to live safely and independently at home.⁵ Individuals who receive personal care services at the local district would also not be eligible for spousal impoverishment budgeting, which is available for MLTC beneficiaries. Spousal impoverishment budgeting allows MLTC beneficiaries to remain in the community while their spouse maintains some income and assets. Depriving a segment of the current MLTC population of this protection could have the consequence of prematurely forcing personal care recipients into a nursing home where spousal impoverishment budgeting is available.

Medicaid beneficiaries in New York have experienced drastic changes in the way they receive their care over the last seven years. As the program continues to shift as we enter the eighth year of the Medicaid Redesign process, vulnerable beneficiaries must not bear the brunt of these changes in a way that compromises access to care. We urge the Legislature to take the opportunity when enacting changes to the program to incorporate provisions that ensure that clear information is provided to beneficiaries and that plans or local districts are held accountable when there are failures of care management or access to services.

The Budget Should Provide Additional Funding for Community Health Advocates

The Legal Aid Society strongly supports the \$2.5 million appropriation for the Community Health Advocates (CHA) program in the Executive Budget, and urges the Legislature to provide an additional \$4.25 million to fortify and expand this critical program.

Since 2010, CHA has provided consumer assistance services to more than 300,000 New Yorkers with both private and public health insurance in every county of New York State. The Community Service Society of New York (CSS) administers the program with the support of three Specialist agencies – The Legal Aid Society, Empire Justice Center, and Medicare Rights Center. CHA supports a network of 25 community based organizations and small business-serving groups that provide services throughout the State and operates a helpline to provide real-time assistance to health care consumers. CHA assists with a wide range of health insurance problems including service denials, billing disputes, and questions about coverage. CSS and the Specialists provide technical assistance and accept referrals of complex cases from organizations throughout the network.

⁵ N.Y. State Dep't of Health, Managed Long Term Care Partial Capitation Contract, Appendix G, https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt90_partial_capitation_model.pdf

With more funding, CHA can help more New Yorkers, shoring up helpline staff to keep up with increasing demand and contracting with more organizations throughout the state where consumers can get assistance in person. Over the last year, CHA has provided up to date information to consumers concerned about what federal changes and potential changes mean for their coverage. In the face of uncertainty about the ACA and the Medicaid program, CHA's role is more important than ever.

We respectfully ask for the Legislature to support CHA with an additional \$2.25 million in funding for the program. In addition, we are seeking \$2 million to reestablish the Small Business Assistance Program (SBAP), which operated from 2012 to 2014, providing small business owners and their employees with assistance and information about health insurance options. This funding could reestablish a network of 15 Chambers of Commerce and small business serving organizations to provide crucial information and assistance to small businesses.

The State Should Move Forward with the Children's Behavioral Health Transition, or Otherwise Address the Needs of Families Impacted by the Delay

The Legal Aid Society is concerned about the impact of the two-year delay of the expansion of children's behavioral health services and other significant changes to the provision of services to high-need children. Delaying the transition at this point could have grave consequences for the children who stood to benefit from the inclusion in the state plan of services such as crisis intervention and psychosocial rehabilitation services. In addition, with an entire system poised to undergo this significant change, backtracking at this point will put untold strain on the providers and agencies that serve this vulnerable population.

The Legal Aid Society currently has a three year old client who requires private duty nursing services which he receives through a Medicaid waiver. Despite contacting dozens of agencies, his family has been unable to adequately staff his case because of fee-for-service payments for nurses that are significantly lower than managed care payments, forcing his parents to be responsible for most of his complex skilled tasks. With the delay of the transition, these kinds of discrepancies in access to services and benefits will likely continue.

We recommend that the transition go forward as scheduled, or with a shorter delay. In the meantime, the state should conduct immediate outreach to impacted providers and consumers to determine the impact of the delay, particularly with regard to access to care and services.

The Budget Should Preserve Spousal/Parental Refusal

The Governor's budget would limit the longstanding right of spousal and parental refusal for vulnerable individuals in New York State (Part B, Section 6). Under the current law, the refusal is applied in situations where a spouse lives apart *or* is unwilling to support the

applicant. As proposed in the Executive Budget, the refusal will only be applied in situations where a spouse lives apart *and* is unwilling to support the applicant.

The Legal Aid Society represents families for whom “refusal” represents the only option to secure affordable coverage. Fortunately, we have observed anecdotally that the need for spousal and parental refusal has lessened as a result of expanded Medicaid eligibility and the availability of subsidized private coverage with the Affordable Care Act. However, this provision remains an essential option for some families who may otherwise be unable to afford coverage. Although the expansion of “spousal impoverishment” protections for individuals in the MLTC program has made spousal refusal unnecessary for some families, spousal impoverishment is only available to those who have already been determined eligible for Medicaid. Therefore, in many cases couples cannot take advantage of spousal impoverishment without using spousal refusal to enroll in Medicaid. There are a number of additional situations in which spousal refusal remains the only option for affordable health insurance:

- Children with severe illnesses not covered by a waiver program, such as those with cancer whose parents cannot afford the high cost of their care;
- People excluded from MLTC, such as those receiving hospice services;
- Married adults who rely on Medicaid for acute and primary care rather than long-term care, and who cannot afford to meet their spend down to access services; and
- Married couples who rely on help with Medicare out-of-pocket costs through the Medicare Savings Program (MSP).

The Budget Should Ensure Due Process and Informed Consent in Comprehensive Medication Management

The new Comprehensive Medication Management Program (Part D, Section 6) has the potential to positively impact Medicaid beneficiaries who have not had their prescriptions well managed in the past. Although the program is voluntary, there is limited information about the ways that the program protects beneficiaries’ due process rights when, for example, a pharmacist makes a change to a method of administration or frequency of a particular prescription. There does not appear to be any requirement that the beneficiary receive notice of the change, other than a notation in the medical record. The Legal Aid Society represents Medicaid beneficiaries who have particular difficulty accessing prescription drugs because they do not receive written denials from their managed care plans. The issue is described as a technical problem and not a denial, complicating beneficiaries’ ability to address it. Similar problems will exist for beneficiaries participating in Comprehensive Medication Management if they are not even provided notice of a change in their access to a drug.

The Budget Should Retain “Prescriber Prevails”

The Executive Budget proposes to eliminate the use of “prescriber prevails” in fee-for-service (FFS) Medicaid and Medicaid managed care (Part D, Sections 4 and 5).

Although prescriber prevails had been largely eliminated from Medicaid managed care previously, exceptions still exist in current law for the anti-retroviral, anti-rejection, seizure, epilepsy, endocrine, hematologic, immunologic, atypical antipsychotics and antidepressant therapeutic classes, recognizing that these classes of drugs treat complex and life-threatening conditions for which precise and appropriate treatment is necessary.

This proposal to eliminate prescriber prevails would have a detrimental impact on people with disabilities and chronic conditions, as well as on those who rely on specific drugs and drug combinations. For these individuals, medical providers are best suited to determine which drug would treat their patients most effectively. Denials of necessary drugs, even if appealed and ultimately resolved in a patient's favor, can endanger Medicaid beneficiaries when they face sudden disruptions in treatment. Providers are best equipped to ensure that their patients have access to the safest and most effective treatments for their conditions.

The Budget Should Not Increase Copayment for Over-the-Counter Medications

We are concerned about the increase in non-prescription drug copayments in the Medicaid program from 50 cents to 1 dollar (Part D, Section 3). Even moderate increases in consumer cost-sharing can interfere with low-income individuals' ability to access coverage. The reality is that many of our clients do not have the money to pay any drug copayments and will miss out on taking needed medicine because they lack the copayment.

It is particularly important that any increase to consumer cost-sharing should be accompanied by meaningful efforts by the state to remind providers and consumers about their rights with regard to accessing services. When the pharmacy benefit was carved in to Medicaid Managed Care in 2011, The Legal Aid Society received many calls from consumers who had been denied prescriptions because they could not afford the copay. Although Department of Health staff were very helpful in resolving individual cases and reminding pharmacies about their obligations, it is inevitable that many more people throughout the state were turned away without their medications and did not make it to an advocate who could help. The problem happened in small pharmacies and huge chains alike. If consumer cost-sharing is increased, plans, pharmacies, and consumers should be advised of Medicaid beneficiaries' right to a drug or supply even if they cannot pay the copayment.

The Budget Should Apply the Increase in the Physical Therapy Cap to Speech Therapy and Occupational Therapy and Allow for a Medical Necessity Exception

The Legal Aid Society supports the increase in the physical therapy cap from 20 to 40 visits (Part A, Section 5). However, this change highlights the serious problems with the cap, especially for disabled and chronically ill Medicaid beneficiaries. This increase will certainly allow more Medicaid beneficiaries to receive appropriate levels of physical therapy. But a better solution would be to allow for physical therapy coverage above the cap to the extent it is medically necessary, aligning this provision with the statutory right to medically necessary services in Medicaid. In addition, it is nonsensical to increase the cap

for physical therapy and not for occupational and speech therapy. Medicaid beneficiaries should not be treated differently depending on the type of therapy needed.

Conclusion

Thank you for the opportunity to testify today. We look forward to working with the legislature to help preserve a strong Medicaid program while protecting beneficiaries' rights.

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