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Testimony of The Legal Aid Society
Joint Legislative Budget Hearing: Health/Medicaid
February 5, 2019

Thank you for the opportunity to testify today in response to the 2019-2020 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.

For more than two years, the Trump Administration has tried to dismantle pillars of our health care system, from the Medicaid program to critical consumer protections in the Affordable Care Act. We are proud to work in a state that is actively opposing the dangerous policies of the Trump Administration. We applaud Governor Cuomo for codifying important parts of the Affordable Care Act and the New York State of Health marketplace in the Executive Budget as well as other consumer protections.

New York's Medicaid recipients have endured significant changes in policies and products over the last decade. It is essential to ensure that the most vulnerable New Yorkers do not lose access to coverage and services as even more policy changes are implemented. We wish to comment on several proposals that we believe could have a significant impact on our clients' health and well-being.

The Budget Should Preserve Existing Regulations Governing Reductions in Care

We strongly oppose the proposal to amend regulations to clarify circumstances in which reductions in care “may be appropriate.”¹ Current regulations provide sufficient flexibility for managed care plans to reduce care if in fact that care is not medically necessary. The Legal Aid Society represents numerous clients who are facing reductions in personal care services or denials of requested increases in care. Our typical client is struggling to get by with many fewer hours of care than is medically appropriate. Frequently, a client’s family members are forced to provide hours of informal care that interfere with their employment, ability to care for their children or other family members, or opportunity to get a reasonable number of hours of sleep.

The proposed regulatory changes could compromise the due process rights of personal care recipients, and would have a particularly deleterious effect on those who are unable to find an advocate or who do not have family members or others able to assist them with the process of appealing a reduction of care. In stark contrast with the implication of this proposal that personal care recipients are receiving unnecessary care, in our experience some plans attempt meritless reductions in care for many enrollees with the expectation that a significant percentage will lack the wherewithal to challenge them. This proposal would empower plans to propose more care reductions. Due process rights should not be compromised in the name of “flexibility.”

The Budget Should Maintain the Consumer Directed Personal Assistance Program

The drastic changes proposed to the Consumer Directed Personal Assistance Program (CDPAP) (Part G, Sections 2-4) put New Yorkers with disabilities at risk of ending up in institutions. The Department of Health has only recently initiated a fiscal intermediary (FI) authorization process to provide increased oversight of FIs. Without allowing the authorization process to mature, the budget proposes sweeping changes to CDPAP that will put most FIs out of business and threaten to disrupt the entire system. CDPAP represents the difference between living in the community and living in an institution for many of our clients with complex needs. Changes of this magnitude should never be initiated without detailed analysis of the impact on the community that CDPAP serves.

The Budget Should Ensure Adequate Funding of Home Care Services

We support the inclusion of \$1.1 billion in the budget to fund the minimum wage increase for all health care workers. However, investment in the health care workforce must be part of an overall strategy to fairly pay home care workers and address the larger crisis in the home care workforce which has endangered consumers and workers alike.

The state needs to provide sufficient funding for home care to ensure that seniors and people with disabilities can remain in their homes and communities in the most integrated setting and to ensure that the workers who provide personal care services to seniors and people with disabilities, including those who work in “live-in” or “sleep-in” shifts, are paid for all of the

¹ Executive Budget Briefing Book, p. 85.

hours they work. The state should mandate that sufficient funds are passed from managed care plans to home care agencies and fiscal intermediaries to adequately pay workers. Employers must be held responsible for tracking all hours worked and paying workers for those hours. The State must require plans and agencies to review the actual activities of home care workers to determine if the consumer is eligible for a higher level of services. The budget must provide funding sufficient to not only pay workers - including those who work 24-hour shifts - for all hours worked, but also to raise wages overall for home care aides. Given the importance of what aides do, helping people with essential tasks of daily living so that they can remain in the community, they should be paid a wage that is high enough to attract people to the occupation and end the shortage crisis. “Sleep-in” or “live-in” shifts should generally be eliminated in favor of split-shift care. In our experience representing home care consumers, and in the experience of my colleagues in Legal Aid’s Employment Law Unit who represent home care aides, it is extremely rare for a worker in a “sleep-in” shift to actually receive the meal breaks and sleep time required by law and regulation and which would allow them to safely care for consumers. There is significant scientific evidence about the deleterious effects of frequently interrupted sleep on overall health.² The state needs to invest adequate funds to allow high needs consumers to safely remain in the community without compromising their health and safety or that of their aides.

The Budget Should Ensure Oversight of Medicaid Transportation Services

We oppose the carve-out of transportation services from Managed Long Term Care (MLTC) (Part A, Section 1) in the absence of provisions to more carefully evaluate the ability of the state’s transportation vendors to provide appropriate services to MLTC enrollees. We understand the utility of aligning the transportation benefits across programs. However, this change, if it goes forward, has the potential to disrupt care. Current law states that the commissioner should adopt quality assurance measures for the transportation vendor “if appropriate.”³ It is not only appropriate but necessary that any transportation vendor with which the state contracts meets stringent quality measures and demonstrates expertise in serving this complex population.

Regardless of how the transportation benefit is administered, it is a Medicaid benefit which affords beneficiaries due process rights when benefits are denied or discontinued. The Legal Aid Society’s clients in mainstream managed care frequently experience long wait times and other complications when booking rides through Medical Answering Services, the vendor serving the New York City area. Because it is not a plan benefit, many mainstream enrollees do not know how to complain about poor service or challenge a denial of transportation benefits.

² See, e.g., Marta Figueiredo, “Women Working Night Shift Show Increased Risk of Breast Cancer, Meta-analysis Suggests,” *Breast Cancer News*, Jan. 12, 2018, available at <https://breastcancer-news.com/2018/01/12/working-night-shift-may-increase-breast-cancer-risk-study-shows/>; Alice Park, “Why Working at Night Boosts the Risk of Early Death,” *Time*, Jan. 7, 2015, available at <http://time.com/3657434/night-work-early-death/>.

³ N.Y. Soc. Serv. L. § 365-h(4).

The state should work to ensure that MLTC members are informed of their rights to access competent transportation services and that these rights are protected. The state should also exercise tighter oversight of transportation providers no matter how the benefit is administered.

Each time there are changes to the way that Medicaid beneficiaries must access benefits and services, there is an increased risk that beneficiaries will lose access to these services. It is crucial that MLTC members' access to transportation to medical appointments be preserved and that plans continue to play a role in coordinating access to the transportation benefit even if they are no longer directly providing the transportation.

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 million to fortify and expand this critical program.

Since 2010, CHA has provided consumer assistance services to more than 330,000 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 27 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.

The CHA helpline number is on all Explanations of Benefits received by private insurance recipients in New York. With the additional funding we are seeking this year, CHA proposes to include the helpline information on all Medicaid managed care denial, reduction, and discontinuance notices. Because of a change in federal regulations, all Medicaid managed care recipients must now exhaust an internal plan appeal before requesting a Fair Hearing on a service denial or discontinuance. This requirement has caused confusion and made it even more important that more Medicaid recipients find their way to an advocate.

Over the last year, CHA has assisted Medicaid recipients with navigating the new appeal requirements, provided up to date information to consumers concerned about the proposed public charge regulations, and provided advice and assistance on myriad other health issues. In the face of persistent federal threats to insurance and benefits, CHA's role is more important than ever.

The Budget Should Include Proposed Behavioral Health Insurance Parity Reforms

We strongly support the proposed reforms to strengthen mental health and substance use disorder (SUD) parity laws and insurance coverage (Section BB). The Legal Aid Society is proud to be a partner in the Community Health Access to Addiction and Mental Healthcare Project (CHAMP),

the new behavioral health ombudsprogram designed to educate consumers on their rights to insurance coverage and help consumers access critical services. We support the proposal to make this crucial program permanent as well as the other parity and insurance reform proposals including prohibiting prior authorization for minors entering inpatient psychiatric treatment, prohibiting insurers from requiring prior authorization to receive medication-assisted treatment (MAT) for SUDs, and codifying important mental health and SUD parity standards.

The Budget Should Recognize the Need for Long Term Intense Care Management for Health Home Participants

The Health Homes program was designed to provide intensive care management for the most vulnerable Medicaid beneficiaries. For certain individuals, it may be realistic to step down the intensity of care management after connecting them to appropriate services and resources. However, for many others, continued intensive care management is required to adjust services to changing needs and to maintain consistent participation in essential programs and benefits. We are concerned that the proposal to disincentize long term intensive care management by Health Homes in favor of enrolling new members prioritizes quantity over quality and contradicts the purpose of the program to help individuals with complex health care needs to remain engaged in appropriate care over the long term.

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 G, Section 1).

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 indispensable 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. Spousal refusal also remains the only realistic option in other circumstances, including for 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; and married couples who rely on help with Medicare out-of-pocket costs through the Medicare Savings Program (MSP).

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 B, Section 3).

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 the Copayment for Over-the-Counter Medications and Should Not Limit Covered Drugs

We are concerned about the increase in non-prescription drug copayments in the Medicaid program from 50 cents to 1 dollar (Part B, Section 2). Even moderate increases in consumer cost-sharing can interfere with low-income individuals' ability to access benefits and services. 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 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 helpful in resolving individual cases and reminding pharmacies about their obligation to provide medications to those who could not pay the copayment, 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 large 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 Executive Budget also proposes to allow the Commissioner to eliminate medications from the list of covered over-the-counter products without notice and comment (Part B, Section 1). This proposal could directly harm consumers who rely on the eliminated drugs, by forcing them to pay full price, go without the drug, or to waste time and money on unnecessary doctors' visits.

The Budget Should Maintain Coverage of Medicare Cost-Sharing

The proposal to limit Medicaid coverage of the Medicare Part B deductible and to eliminate the "hold harmless" provision in Medicare ambulance and psychologist services (Part C, Sections 2-3) has the potential to compromise Medicare/Medicaid dual eligibles' access to providers and increase the likelihood of illegal balance billing.

We frequently hear from our clients who are Medicaid beneficiaries about their difficulty finding and keeping doctors. When changes were implemented in 2015 that limited payments for dual

eligibles to the lesser of the Medicare or Medicaid payment, we heard many anecdotes about providers dropping their dual eligible patients or illegally putting pressure on them to pay the Medicare coinsurance. By reimbursing providers for only part of the Medicare deductible, and lowering the payments for ambulance and psychologist services, this provision will likely make it more difficult for dual eligibles to find doctors. This proposal should not move forward without research into the projected impact on access to providers for dual eligible beneficiaries.

Conclusion

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

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