CID-NY

Manhattan
841 Broadway
Suite 301
New York, NY 10003
212/674-2300 Tel
212/254-5953 Fax
646/350-2681 VP

Queens
80-02 Kew Gardens Rd
Suite 107
Kew Gardens, NY 11415
646/442-1520 Tel
718/886-0428 Fax
866/948-1064 VP

www.CIDNY.org

Center for Independence of the Disabled, NY

Testimony to the Joint Budget Hearing of the Senate Finance Committee and Assembly Ways and Means Committee on the Executive Budget - Health Care

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Testimony by:

Heidi Siegfried, Esq.

Director of Health Policy

Center for Independence of the Disabled

This testimony is submitted on behalf of Center for the Independence of the Disabled, NY (CIDNY), a non-profit organization founded in 1978. CIDNY's goal is to ensure full integration, independence and equal opportunity for all people with disabilities by removing barriers to full participation in the community. We appreciate the opportunity to share with you our thoughts about the New York State's Executive Budget Proposal and our recommendations. Because the conditions affecting the individuals and families we represent do not discriminate between rich and poor, we advocate for accessible, affordable, comprehensive and accountable health insurance for the privately insured, as well as for those in need of access to public insurance programs.

CIDNY strongly opposes the Medicaid Redesign Team approach of cutting $5 billion from the Medicaid program.

The proposed Executive Budget reconvenes the Medicaid Redesign Team (MRT) and directs the MRT to report back before the April 1 budget deadline with a plan to deliver $5 billion in cuts to Medicaid. Medicaid is an essential program that provides coverage and vital services to people with disabilities and other low-income individuals. We are gravely concerned that directing a group of providers to find savings in such a short time period will create a process that does not allow for public input, or time to consider the implications of the proposals put forward and how they will impact access to vital services.

The Governor has directed the MRT not to cut eligibility or benefits in the program, but people with disabilities have endured the experience of the cuts made by the first MRT and are fearful of what additional cuts to eligibility or benefits could be made.

Specifically, the legislature adopted the recommendation of the first MRT to place a 20 visit annual limit on Physical Therapy, Occupational Therapy, and Speech Therapy which harmed many CIDNY consumers. One person who reached the limit in April and had to go without physical therapy for the rest of the year and experienced a decline in functioning. Some people had to resort to surgery because they were not able to get an adequate amount of therapy after which they were supposed to have post-operative therapy. Elsewhere in our testimony we discuss our years of efforts to get this service cut restored by putting language into one house budgets or introducing stand alone legislation which have all been to no avail.

Managed care for all and the mandatory enrollment of dual eligible into Managed Long Term Care has also resulted in severe cuts to home care hours which have only been restored by requesting fair hearings against the MLTC. A typical example would be a proposed cut of home care to 4 hours in the morning and 4 hours in the evening to a person who previously got 24hours/7 days of home care because they need to be turned and repositioned every two hours to avoid bedsores. The fact that this could result in the need for hospitalization or wound care nurse visits is not considered by the MLTC (probably because they may not be the payor for these services) and the medically necessary services have to be restored by an Administrative Law Judge.

We are gravely concerned that this process, which to date appears to include only providers, will not prioritize the State's obligations under Olmstead to ensure people have access to the support and services they require to live in the community.

Medicaid is a critical program that New York uses along with federal matching funds to take care of its people with disabilities and seniors. The state must not rely solely on program cuts to address the budget shortfall. Instead, the State must address both sides of the equation by also seeking out ways to raise revenue. Our economy is booming and there is no reason why we cannot raise the revenue we need from the over 100 billionaires and many more multi-millionaires who make New York their home and are part of the family of New York. A menu of 14 possibilities for raising revenue that totals $35 billion has been suggested by other budget players that should be considered by the legislature.

CIDNY opposes the Medicaid Global CAP. Since 2011 the Medicaid Program has been operating under a Medicaid global spending cap which has meant that essential programs and services that are important to the well-being of people with disabilities have faced significant cuts in recent years. Many of these cuts have occurred "behind the curtain", but as mentioned in the example above Managed Long Term Care Plans have cut home care hours in ways that have adversely impacted people with disabilities, which may mean that people whose hours are cut are forced to give up their independence and move into institutional care.

The Trump administration is working on ways to let states implement block-grant systems in their Medicaid programs. Experts have commented that this could result in "insufficient funding that could lead to inadequate capitation rates that are no longer actuarially sound." That certainly has been our experience in New York. New York's economy is strong austerity seems cruel and unnecessary. The State needs to continue in its tradition of providing community-based services to low-income individuals and people with disabilities. It is time for New York to end this arbitrary global cap.

CIDNY SUPPORTS CONSUMER ASSISTANCE FUNDING

CIDNY supports increased funding for Community Health Advocates (CHA), the state's health care consumer assistance program, to $5 million. Since 2010, CHA has helped 359,000 New Yorkers, including many people with disabilities, all over New York State navigate their health insurance plans to get what they need and saved New Yorkers over $47 million. People with serious illnesses and disabilities especially need this assistance so that they can get the services and supports that are right for them. CHA's contact information is listed on commercial, but not Medicaid Managed Care notices. Medicaid patients now have to "exhaust" their Plan's internal appeal systems before going to an independent appeal process. Medicaid enrollees should receive CHA's information to manage the appeal process as people in the commercial markets already do. The Governor proposes a budget for the program of $2.5 million. *We urge the Legislature to add $2.5 million for a total of $5 million for fiscal year 2021*.

CIDNY supports increased funding for the Long-term Care Ombudsprogram. TheGovernor proposed level funding in his Executive Budget for the Long-term Care Ombudsprogram--a program with a mandate to protect New York's nursing home residents. The program is dealing with downsizing and closures, discharge of residents to homeless shelters, psychotropic drugging and other serious problems with only minimal resources. Currently, New York's program is one of the most poorly funded in the nation. Last year the State Comptroller released a report which found that many residents in LTC facilities lack representation from an Ombudsman due to lack of volunteers and paid staff. The report found that statewide, there are about half the recommended number of full-time staff. It found that in New York City alone, 23 more full-time staff would be required. *The legislature should increase state share funding of the Long-term Care Ombudsprogram by $3 million.*

CIDNY supports enrollment assistance by New York State Navigators urging the State to increase the budget to $32 million. Navigators are local, in-person assisters that help consumers enroll in health insurance plans. Navigators have helped over 300,000 New Yorkers enroll since 2013 without ever receiving a cost-of-living increase*. The State should increase the navigator budget from $27.2 million to $32 million to guarantee high quality enrollment services.*

CIDNY urges the State to provide $2 million for outreach to uninsured New Yorkers. One third of the remaining uninsured are eligible for free or low cost coverage, but are unaware of it. This is especially important for people in immigrant communities, including people with disabilities, who are living in a state of great uncertainty because of federal threats like "public charge". *The State should provide $2 million for community based organizations to conduct outreach and educate consumers in the hardest-to-reach communities.*

Community Health Access to Addiction or Mental Healthcare Project (CHAMP). Insurance barriers stop many New Yorkers from getting care for mental health or substance abuse issues. CHAMP started in 2019 and has already helped thousands of New Yorkers resolve those issues and get necessary care. CHAMP only received $1.5 million in 2019—for 2020 it should be fully funded at $3 million.

Medical Billing Protections. New Yorkers need protection from unfair medical billing practices. **A8639 (Gottfried)/S6757 (Rivera)** would eliminate some of these practices by requiring consolidated, clear hospital bills and capping interest on medical debt. It would also protect consumers from surprise out-of-network bills caused by provider or plan misinformation; protect patients from unfair facility fees; and reduce the statute of limitations on medical debt to two years from six.

The Executive Budget includes two proposals which CIDNY supports that will help patients facing lawsuits over unpaid medical bills:

- <u>First, it reduces the number of years (or the statute of limitations) hospitals have to sue their patients from six years to three.</u> Hospitals currently have up to six years to sue a patient for an unpaid medical bill. By the end of six years, many consumers will have changed insurance companies or lost copies of bills

and other records relating to their medical care. Part J, section 18 of the Executive Budget's Health and Mental Hygiene VII legislation proposes to reduce this statute of limitations to three years. This matches the practice in most other states and gives consumers a much better chance of defending themselves.

- Second, it reduces the amount of interest a not-for-profit hospital can pursue from the commercial rate of 9 percent to the one-year treasury rate. This would have a profound impact on patients' lives. Part T of the Executive Budget's Public Protection and General Government Article VII legislation includes language that would limit the annual interest that can accrue on a civil judgment or claim to the one-year United States Treasury bill rate. For 2020, the Treasury rate is only 1.54 percent.

CIDNY SUPPORTS AFFORDABLE COVERAGE

Ensuring Coverage for All New Yorkers with Affordable Coverage Options. The Essential Plan is a popular health program that offers coverage for at most $20 a month with no deductible. People who earn too much for the Essential Plan must buy coverage on the Marketplace which can cost $150 or more and have deductibles that are over $1350 – even with financial assistance. New York could ease this affordability cliff by allowing by allowing people who earn between 200% and 250% of the federal poverty level (around $25,000 for an individual) to choose between buying a private plan or buying the Essential Plan.

The State should explore establishing a premium assistance program for people with incomes over 200% of the federal poverty level who buy private insurance. Federal tax credits cap premiums at a specific percentage of household income, but do not go far enough. Making coverage more affordable would help address individual consumers' budget challenges, but also brings down prices for the entire individual market by bringing more people into the risk pool.

Federal premium subsidies limit the percentage of income spent on health care premiums for those who earn up to 400 percent of the federal poverty level (for an individual, about $49,000 a year). However, high deductibles and other out-of-pocket costs often mean that people cannot afford to use their plans even with lowered premiums. New York could add additional premium subsidies on top of the federal subsidies to help further reduce monthly spending on health insurance. New York could also add premiums for people earning between 400 and 600 percent of the federal poverty level, as Governor Newsom has proposed to do in California.

A benefit of this approach is that if New York subsidizes plans enough, it could lower prices in the individual market even for people who are not receiving the subsidies. Targeting the subsidies so that they bring the most people into the market would improve the risk pool, which would drive down premiums for everyone.

CIDNY SUPPORTS ACCESS TO CARE

CIDNY supports the New York Health Act

CIDNY has long supported various versions of Single Payer Universal Health Care which would establish a seamless comprehensive system for access to health coverage and care. People with disabilities have a right to a transparent, accountable health care system that provides accessible coverage including benefits and services that are based on medical necessity. The current disjointed system of Medicare, Medicaid, and private commercial coverage and other specialized programs is difficult to navigate and often fails people with disabilities.

The New York Health Act would end the chaotic medical care system that people with disabilities are all too familiar with and its multiple uncoordinated programs, restrictive networks and formularies, deductibles and copays which can function as barriers to care. We are particularly pleased to be able to support the New York Health Act A5248 (Gottfried)/S3577 (Rivera) as introduced this year since its comprehensive benefits now include long-term care, as well as primary and preventive care, prescription drugs, laboratory tests, rehabilitative and habilitative care, dental, vision and hearing. For people with disabilities, who may have multiple providers, the free choice of care coordination as a separate service to help get the care and follow-up the patient needs that does not operate as "gatekeeper" is an added plus. CIDNY appreciates the articulation of program standards that include the accessibility of care coordination, health care organization services and health services, including accessibility for people with disabilities and people with limited ability to speak or understand English. We also appreciate the maximization and prioritization of the most integrated community based supports and services. CIDNY looks forward to the passage and implementation of this important legislation.

CIDNY seeks legislation that would prohibit dropping drugs from a formulary or moving them to a different tier. A2969A (Peoples-Stokes)/S2849A (Breslin)

CIDNY supports this legislation which would prohibit dropping of drugs from health plan formularies or adding higher cost sharing or new utilization review requirements for drugs already on formulary unless, in the case of movement of a drug into a higher cost-sharing tier, a generic equivalent for that drug is being added to the formulary.

One of the most important things a consumer checks in determining what health plan he or she will enroll in is whether the prescription drugs on which that individual depends are covered in the plan's formulary. Restricting mid-year formulary changes introduces a measure of fairness. Consumers who pick a plan because it covers their drugs will have the assurance that the reason for their choice will remain in place for the entire year for which they are committed to that plan.

CIDNY seeks legislation that would ensure that a person can get their medication through their local pharmacy if that option work better for them than using a mail order pharmacy.

CIDNY supports the passage of A3043 (Joyner)/S4463(Breslin). This legislation would ensure that consumers have the choice of accessing every covered medication through a network participating retail pharmacy or a network participating mail order pharmacy. It would also prohibit a prescription benefit plan from requiring a higher co-payment for a drug dispensed by a network retail pharmacy and would prohibit plans from requiring a network retail pharmacy to agree to additional terms and conditions that go beyond the industry standard in order to dispense specialty prescription drugs.

Consumers should have the choice of accessing their covered medications from a local pharmacy or by mail order depending on which best meets their needs. Legislation which went into effect in 2012 was supposed to guarantee this choice, but consumers continue to be directed to out-of-state specialty pharmacies and are unable to fill their prescriptions at local pharmacies.

While some people might prefer to have their prescriptions mailed, some people have no mailing address other than a post office box or they live in neighborhoods where mail delivery is unreliable and is not secure. Mail order pharmacies typically deliver only to a residence or work address and often require a signature. Delivery to a work site can jeopardize confidentiality and result in a disclosure that could lead to discrimination or other unwanted attention. All of these problems are exacerbated when a medication requires refrigeration.

Patients who have difficulty communicating and comprehending pharmaceutical guidance and support over the telephone due to the language they speak or a cognitive or other disability may need the in-person support of a local pharmacist rather than a call center to best understand their medication regimen.

NY Medicaid and Medicaid Part D provide patients access to medications at a local pharmacy. Patients across the state in commercial plans also need this access.

CIDNY Supports an Override Provision for Visit Limits on Medicaid Physical Therapy, Occupational Therapy and Speech Therapy.

Last year's Executive Budget increased physical therapy visit limits from 20 to 40, but speech therapy and occupational therapy remain at 20 visits annually. Arbitrary visit limits do not make sense, and discriminate against people with disabilities. People who have a stroke may need more visits to regain the ability to walk. We have seen a person subjected to these limits who was unable to get the recommended post-operative physical therapy needed to regain functioning. Some people may experience depression when they are unable to gain or regain function and thus may require therapy or prescription drug treatment.

Medicare provides for an override and Medicaid Utilization Thresholds, which have been used in New York, have provided a procedure for a physician override.

CIDNY supports A4846 (Barrett) which enables patients to receive coverage of medically necessary speech, physical, and occupational therapy services under Medicaid beyond the annual limit based on medical necessity attested to by the physician nurse practitioner who directed the visits or the provider.

Medicare provides for an override and Medicaid Utilization Thresholds, which have been used in New York, have provided a procedure for a physician override.

CIDNY supports the "safe staffing for quality care act." A2954 (Gunther)/S1032 (Rivera)

CIDNY supports legislation that would require acute care facilities and nursing homes to implement direct care nurse to patient ratios and minimum staffing requirements. CIDNY supports minimum care hours per nursing home resident, per day for Registered Nurses, Licensed Practical Nurses (LPNs), and Certified Nurse Assistants (Certified Nurse Assistants) and would impose civil penalties for violation of these requirements. The minimum hours of care per resident, per day are as follows: RNs: 0.75 hours divided among all shifts to provide an appropriate level of RN care 24 hours per day, seven days a week; LPNs: 1.3 hours; and CNAs: 2.8 hours. CIDNY looks forward to recommendations from the study commission established in this year's budget.

CIDNY Seeks Fair Funding for Safety-Net Hospitals. A6677B (Gottfried)/S5546A (Rivera)

Under the current allocation of funds from New York's indigent care pool, true safety net hospitals, which serve uninsured people and have a high volume of Medicaid patients, like New York City Health + Hospitals, will face a disproportionate share of the burden from any cuts. People with disabilities disproportionately use public coverage like Medicaid for their health insurance and so are disproportionately served by these hospitals.

The Legislature needs to fix the inequities in the hospital Indigent Care Pool and Disproportionate Share Funding by ending the Indigent Care Pool transition collar and adopting legislation to allocate DSH and ICP funds in NYS to ensure continuation of true safety net hospitals and provision of services to their patients.

CIDNY seeks legislation that would improve community impact analysis before hospitals close or merge.

More than 40 hospitals have closed across New York State and other hospitals have eliminated maternity units, emergency departments and other time sensitive services. Affected communities often have little or no say. CIDNY supports A2986A(Simon)/S5144A(Kavanagh) that would require advance public notice and a public hearing to gather consumer comments that would inform a final closure plan, including identifying and addressing any projected service gaps that would occur.

CIDNY seeks legislation that would require community advisory boards at all hospitals.

Voluntary non-profit hospitals are required to have a community service plan, but they are not required to have community advisory boards. CIDNY strongly supports A1148(Gottfried)/S1856(Hoylman), that would require all general hospitals to have community advisory boards to provide input as the hospitals develop their community service plans and provide ongoing insight into community needs and priorities. This could provide an opportunity to make sure that hospitals fulfill their responsibilities to provide reasonable accommodations to people with disabilities.

CIDNY seeks legislation that would increase consumers on the Public Health and Health Planning Council.

The Public Health and Health Planning Council makes decisions that affect the cost and availability of care without providing enough opportunities for consumers to weigh in. CIDNY supported A4071(Gottfried)/S870(Hoylman) that would add, among others, more members to represent the consumer perspective. The Governor vetoed that legislation but directed Commissioner Zucker to appoint two consumer members to the PHHPC. CIDNY supports legislation that would expand the membership to allow for those appointments.

CIDNY seeks legislation that extends the Essential Plan to people whose immigration status makes them ineligible for federal financial participation.

CIDNY strongly supports A.5974(Gottfried)/S.3900(Rivera). This bill provides adult immigrants with access to health insurance coverage that is *equivalent* to the coverage offered to their fellow citizens or lawfully present counterparts who are eligible for the Essential Plan because their income is below 200% of the Federal Poverty Level. In New York City, 58% of people with disabilities have incomes below 200% of the Federal Poverty Level. Some of these New Yorkers with disabilities are people with immigration statuses that preclude Essential Plan eligibility.

Extending eligibility to these immigrants builds upon New York's success covering children through the Child Health Plus program which *does* including immigrant children. It extends coverage to eligible adult immigrants ensuring that all New Yorkers have access to affordable health coverage, averting the health insurance cliff many young immigrants now face when they turn 19 after years of state investment in their health.

Physical Therapy, Occupational Therapy, and Speech Therapy should be subject to an override. Last year's Executive Budget increased physical therapy visit limits from 20 to 40, but speech therapy and occupational therapy remain at 20 visits annually. The Medicaid Redesign Team adopted the recommendations of its Basic Benefit Review Workgroup that included the principle that decisions on the Medicaid Benefit package would be based on evidence derived from an assessment

of effectiveness, benefits, harms, and costs. Arbitrary visit limits do not make sense, and discriminate against people with disabilities. People who have a stroke may need more visits to regain the ability to walk. We have seen a person subjected to these limits who required surgery as a result, and then was unable to get the recommended post-operative physical therapy due to the limit. Some people may experience depression when they are unable to gain or regain function that may require therapy or prescription drug treatment. Medicare provides for an override, and Medicaid Utilization Thresholds which have been used in New York have provided a procedure for a physician override. *On override procedure should be implemented for these limits.*

For further information, please contact Heidi Siegfried, NYFAHC's Project Director, at 646.442.4147 or hsiegfried@cidny.org.