



Empire Justice Center

119 Washington Ave. ♦ Albany, NY 12210
Phone 518.462.6831 ♦ Fax 518.462.6687

www.empirejustice.org

**New York State Legislature
2018-2019 Joint Budget Hearing:
Health/Medicaid**

February 12, 2018

**Prepared and Presented by:
Adam Prizio, Health Attorney
Empire Justice Center
119 Washington Avenue
Albany, NY 12210**

Introduction

My name is Adam Prizio and I am the Health Law & Policy Attorney in the Albany office of Empire Justice Center. I would like to thank you for the opportunity to testify today concerning the 2018-2019 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 areas including health, immigration, 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 HCFANY and MMNY'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. Restore and Invest in Community Health Advocates**
 - Contribute \$2.25 million to bring CHA funding up to \$4.75 million
 - Fund the CHA Small Business Assistance Program for \$2 million
- 2. Make “Community Integration for Every New Yorker” a Reality**
 - Oppose the nursing home carve-out
 - Address the home care workforce shortage.
- 3. Ensure that All New Yorkers have Access to Health Benefits**
 - Relieve Medicaid users of excessively low PT/OT/ST caps;
 - Preserve prescriber prevails;
 - Preserve affordable over-the-counter drugs;
 - Protect access to prescription opioids for pain management;
 - Oppose the LHCSA cap;
 - Oppose the marketing ban on community based services.

4. Oppose Changes to Eligibility Requirements that Create Barriers to Necessary Care

- Preserve spousal and parental refusal;
- Change spousal impoverishment to the Federal maximum allowed, rather than changing it to the minimum;
- Oppose changes to the NFLOC score and continuous care requirements for MLTC;
- Protect consumers' ability to change their MLTC plans;
- Keep MLTC members enrolled during the first 30 days when services are being set up;
- Raise the age limit for Child Health Plus to 29.

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 302,000 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 \$27 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. And we are truly grateful for the Assembly's steadfast and growing support of CHA over the years. But the need is growing as well. This year we are asking both houses of the Legislature to allocate funding to restore last year's level and provide enhanced funding for a total of \$4.75 million. This will allow CHA to address the growing fear and concerns raised by New Yorkers as a result of potential and actual 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 support CHA by investing \$2.25 million, increasing the \$2.5 million in the Executive Budget to a total investment of \$4.75 million. This 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.

Recommendation: Provide \$2 million to fund the CHA Small Business Assistance Program.

In 2012, recognizing the need for health advocacy services for small business owners, the CHA network created the Small Business Assistance Program (SBAP). This first-in-the-nation program, built off CHA's "hub and spokes" model, was a network of 34 organizations, including 13 Chambers of Commerce and 4 Small Business Development Chambers which provided health advocacy and assistance to small businesses and their employees. SBAP funding ended in 2014. From 2012 to 2014, SBAP reached 28,575 small businesses around the state through 6,064 individual counseling sessions and presentations to 22,511 people.

We are asking the legislature to allocate \$2 million to revive the SBAP in order to assist New York's small businesses in this time of great uncertainty and change in health policy.

Make "Community Integration for Every New Yorker" a Reality

The 1999 Supreme Court decision in *Olmstead v. L.C.*, 527 U.S. 581, found that people with disabilities have a right to live in the most integrated setting appropriate to their needs. For years before *Olmstead* and the Americans with Disabilities Act, the assumption that a nursing home or other institution was an appropriate setting for people with disabilities and seniors to live out their lives was barely challenged. *Olmstead* changed the conversation. The language of community integration transformed expectations for people with disabilities and our growing aging population – living in the community and avoiding a nursing home is now considered a real option. While this puts pressure on the home care system, we should not be quashing the expectations and dreams of people who wish to live their lives in the comfort and familiarity of their homes and communities, instead of the dehumanizing and depressing environment of an institution.

But movement from an aspirational conversation about community integration to a society and State where community integration is realized has been slow going, even with the legal requirement to move people with disabilities to the community. Shifting the focus away from institutions toward the community requires more than lip service. New York must invest in community integration. That is the only way to show we truly value the lives of the people with disabilities and seniors who want to

live in the community, and the lives of the people - the home care workforce - who help make that happen.

Recommendation: Oppose proposals to carve out of eligibility for Managed Long Term Care individuals who have been placed in nursing facilities. Instead, create mechanisms and provide sufficient funding to ensure that people who wish to live in the community have full access to services and supports necessary for them to do so.

The Executive Budget proposes to add “a person who is permanently placed in a nursing home for a consecutive period of six months or more” to the categories of New Yorkers ineligible to enroll or remain in Managed Long Term Care (MLTC).¹ This proposal creates a substantial financial incentive for MLTC plans to unload costly high service need members by moving them from the community into nursing homes. Rather than authorizing, paying for, and managing services that would enable these individuals to live in the community, plans will be able to push people off of their own books and out of the MLTC program entirely. By relieving MLTCs of the burden of paying for nursing home care and providing them with a cost-free place – nursing facilities -- to dump high need members, this proposal will reverse what little progress New York has made in fulfilling the promise of “community integration for every New Yorker” laid out in the Governor’s Olmstead plan.²

The State is well aware that carving the nursing home benefit out of MLTC could undermine community integration efforts. Indeed, the Governor’s Olmstead report identified making managed care plans responsible for nursing home care as a key policy “to support community living for people with disabilities residing in, or at risk of placement in, nursing homes.”³ According to the Governor’s 2013 Olmstead Implementation Plan:

[R]eforms in the 2012-2013 budget removed the financial incentives that may have encouraged nursing home placement. Previously, nursing home costs were “carved out” of managed care rates and were instead covered by the state. This policy had the potential to encourage managed care plans to pressure high-cost people served in community-based settings to enter nursing homes. Budget reforms will include the full cost of nursing home care in managed care rates, which is expected to encourage these plans to seek lower cost, community-based services.

Yet, despite acknowledging the financial incentives plans will have to favor nursing home institutionalization over community integration for high cost individuals, the Executive Budget does not contain a single proposal that would address this concern.

The term “permanently placed” is revealing in the context of the Governor’s proposal. The Disability Community is filled with people who, after having been “permanently placed” in a nursing facility for years, have successfully transitioned back into the community. In the vast majority of these cases, the

¹ 2018 Health and Mental Hygiene Article VII (HMH), Part B § 5.

² <https://www.ny.gov/programs/olmstead-community-integration-every-new-yorker>.

³ “Report and Recommendations of the Olmstead Cabinet,” available at https://www.ny.gov/sites/ny.gov/files/atoms/files/Olmstead_Final_Report_2013.pdf.

transition was not predicated upon a change in condition but upon the availability of community based services to meet the individual’s needs in an integrated setting. Many disabled people spend more than six months in a nursing facility before home and community based services can be put into place and an accessible dwelling can be secured. Setting up these services involves the work of community transition specialists, care managers, service coordinators, and, when necessary, attorneys from Empire Justice and other civil legal services organizations to protect the *Olmstead* integration rights of disabled New Yorkers.

The mere fact that an individual has a right to live in the community does not mean that every New Yorker who wishes to exercise that right is allowed to do so. Crisis-level shortages of personal attendants and other community-based services statewide, as well as the lack of affordable, accessible, integrated housing, and a lack of accessible public transportation in many parts of the state, obstruct the integration of many disabled people of all ages, and many seniors with disabilities. A lot of things have to go right before a consumer can transition from a nursing home into the community. It can easily take longer than six months.

Excluding people “permanently placed” from MLTC will cut off many disabled people and seniors from the primary source of home and community based services. Transitioning out of a nursing facility will go from being very difficult in practice to impossible. This proposal has grave consequences for the *Olmstead* rights of disabled people and seniors, and we urge the legislature to oppose it vigorously.

Instead of segregating disabled people and seniors, Empire Justice urges the Department of Health to engage with MLTC consumers, plans, and providers to ensure that the capitation payments effectively incentivize the provision of community-based services, and that the reimbursement is adequate to ensure that providers can meet the demand for those services. To ensure this, consumer advocates, including Empire Justice Center, have long called for the creation of a high needs community rate cell which we believe the Legislature should embrace as well.

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

At the same time that the Executive proposes to relieve MLTC plans of the cost of nursing home placement, the budget contains little to address the shortage of home care workers for Medicaid recipients who receive home and community based services that support their integration. In order to realize the promise of “community integration for every New Yorker,”⁴ community-based long term services and supports, including homecare, must be widely available and in fact provided to New Yorkers who wish to live in the community.

New York Medicaid recipients are entitled to home care if they are found eligible for it. It’s that simple. And yet time and again Empire Justice and other legal services organizations are contacted by and about Medicaid recipients who everyone agrees should be getting home care – their doctor, their

⁴ <https://www.ny.gov/programs/olmstead-community-integration-every-new-yorker>.

Medicaid plan, their family, an Adult Services worker who was called in. But by and large they are not getting any services, or they are getting less care than they need, or they are getting intermittent care. As a result, the recipients are left to fend for themselves, risking institutionalization, and putting their lives and health in danger.

Last year the Assembly Committees on Aging, Health, and Labor, and the Task Force on People with Disabilities, held hearings in New York City and in Albany regarding the home care workforce shortage. At those hearings, advocates for seniors and disabled people, providers, LDSSs, and Managed Care plans, for perhaps the first time in the history of New York health policy, spoke in agreement.⁵ They said, the shortage is real, it is widespread, and it is caused because home care workers are not paid enough for the hard work that they do. The record of those hearings is illuminating, and it bears review today, for the problems those hearings showcased have not been addressed.

The shortage exists both upstate and downstate, and is so pronounced in some areas upstate that home care services functionally do not exist in those regions. We hear from advocates and individuals that LDSSs 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. 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.

Relatively recently, home health aides were included in the Fair Labor Standards Act's overtime and travel time requirements. This inclusion has, perversely, only intensified the aide shortage of workers. Personal care providers as well as some fiscal intermediaries are capping aide hours to avoid the overtime and travel-time costs associated with these new requirements, further reducing the already insufficient workforce.

The home care workforce shortage persists across Medicaid programs.⁶ We have seen it in fee-for-service Medicaid at the Local Departments of Social Service (LDSS), MLTC, Mainstream Managed Care (MMC), and through the TBI and Nursing Home Transition and Diversion Waivers.

⁵ Empire Justice Center's testimony at that hearing, including supporting documents showing the harm of cuts to home care resulting from this shortage, is available at: <http://empirejustice.org/wp-content/uploads/2018/01/ejc-home-health-aide-testimony-2017.pdf>.

⁶ There are several avenues through which Medicaid recipients in New York State receive home care services:

- Mainstream Managed Care (MMC): MMCs are responsible for assessing and approving their members for home care services.
- Managed Long Term Care (MLTC): MLTC provides home care services to people dually eligible for Medicaid and Medicare who need more than 120 days of community based long term care services other than level one personal care services. Medicaid-only individuals may also receive home care through MLTC, but must, in addition to other eligibility requirements, meet a nursing home level of care and need at least one of three services that are available in MLTC, but not MMC: environmental or social supports, home delivered meals, or social adult day care.
- Local Department of Social Services/NYC Human Resources Administration: LDSS/HRA is responsible for ensuring the provision of home care for people on fee-for-service Medicaid (e.g., someone with third party health insurance other than Medicare); dual eligibles only eligible for level 1 personal care services or who need higher level services for less

LDSSs are still responsible for authorizing and providing home care to individuals in fee-for-service Medicaid, dual eligibles not eligible for MLTC, people with an immediate need for personal care services or consumer directed personal assistance, and a number of waiver recipients. Many LDSSs readily acknowledge their inability to meet the need for home care.

Some plans in the managed care system have responded to the workforce shortage with a variety of tactics including:

- rationing care by authorizing only the number of hours they believe they can fill, not the number of hours that a member needs;
- pressuring clients to use the Consumer Directed Personal Assistance Program,
- sometimes offering to authorize more hours under CDPA than for personal care, thereby shifting the onus of finding aides on to the member; and
- discouraging people with high needs from enrolling in the plan by claiming the plan cannot safely serve the person in the community or does not provide the 24 hour care the applicant needs.

In addition, 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.⁷ 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. In some cases, the managed care plan has refused to comply with an adverse Fair Hearing outcome.

We understand that there are real challenges to solving this problem. But morally and legally, the crisis cannot be allowed to continue and must be reversed. With that in mind, we urge the following immediate steps to begin addressing the workforce shortage:

1. Ensure adequate competitive wages and benefits for home health aides, personal care aides and consumer directed personal assistants. Immediately, this means:
 - Requiring the minimum wage for home health, personal care and consumer directed workers statewide to be equal to or greater than the minimum wage for fast food workers.

than 120 days, people with an immediate need for personal care services or consumer directed personal assistance, and TBI and NHTD waiver participants who do not receive Home and Community Support Services, or who additionally need home health services or private duty nursing.

- The TBI and NHTD waiver programs: Waiver program recipients who need Home and Community Support Services (oversight and/or supervision as a discrete service) receive any necessary personal care services through the waiver.

⁷ 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>.

- Requiring reimbursement for aide travel time.
 - Providing the necessary funds to pay competitive wages and benefits to aides as well as to pay for FLSA overtime and travel time requirements. This includes providing managed care capitation payments sufficient to cover these costs, and requiring that these increases be used to increase the availability of aide services. Managed care plans must, in turn, provide sufficient rates to Licensed Home Care Service Agencies, CDPA Fiscal Intermediaries and Certified Home Health Agencies that account not just for wages and benefits, but also administrative costs associated with these increased wages. Provider agencies must, in their turn, use the increased reimbursements to meet minimum wage and overtime requirements and to increase wages above the minimum wage in order to attract and retain aides. LDSSs must also be able to offer competitive reimbursement rates to home care agencies that they then pass on to workers. Currently counties cannot compete with the rates offered by managed care, even as the managed care rates are inadequate 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 MLTC.
2. Convene a stakeholder workgroup to investigate and make recommendations on ways of recruiting and retaining people in the home care workforce. The workgroup should be charged with exploring and making recommendations on recruiting and retaining an adequate and adequately compensated home care workforce that will permit all seniors and people with disabilities who wish to live in the community to do so. The workgroup must have the authority to make policy recommendations as well as recommendations for changes to state law and regulations. The workgroup must contain substantial representation from home care recipients, home care workers and organizations that represent their interests.
 3. 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 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).

Ensure that All New Yorkers Have Access to Health Benefits

Recommendation: Support raising the Medicaid cap for physical therapy to 40 visits, but include as well a medical necessity exemption for physical, occupational and speech therapy in Medicaid.

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. The cap 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. The Governor has proposed this year to double to 40 the cap on physical therapy, while leaving the other caps untouched.⁸ While this proposal is a move in the right direction, it is time for New York to create a medically necessary exception to the cap on all three therapies.

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

- 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.⁹
- 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."¹⁰
- 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.¹¹
- 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.¹²

⁸ HMH Part A § 5.

⁹ Decision After Fair Hearing, FH# 7338295P, Aug.. 29, 2016, available at http://otda.ny.gov/fair%20hearing%20images/2016-8/Redacted_7338295P.pdf.

¹⁰ Decision After Fair Hearing, FH# 7318664Z, Aug. 2, 2016. Available at http://otda.ny.gov/fair%20hearing%20images/2016-8/Redacted_7318664Z.pdf

¹¹ Decision After Fair Hearing, FH# 7299981Y, Jun. 24, 2016 http://otda.ny.gov/fair%20hearing%20images/2016-6/Redacted_7299981Y.pdf

¹² Decision After Fair Hearing, FH# 7282819M, May 13, 2016, available at http://otda.ny.gov/fair%20hearing%20images/2016-5/Redacted_7282819M.pdf.

- 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.¹³

These 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 enrolled in Medicare, the Essential Plan, or a qualified health plan (QHP), they would have had the opportunity to obtain 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.¹⁴

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. 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 or more disabled than their counterparts in commercial plans. The Medicaid program should no longer seek savings at the expense of individuals' ability to 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.

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

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

¹⁴ 42 U.S.C. § 1396r-5l(g).

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.

medications.¹⁶ 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.

Recommendation: Oppose increases in drug costs for Medicaid beneficiaries.

The Executive budget proposes that the price Medicaid beneficiaries pay for over-the-counter medication double (from 50 cents to \$1).¹⁷ This increase is significant for many low income Medicaid beneficiaries who take a regimen of multiple medications, including over-the-counter drugs, to manage their illnesses. Even moderate increases in copayments can cause low income individuals to forego care.¹⁸ Although Medicaid beneficiaries who cannot afford copays 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.

Recommendation: Protect Access to Pain Management Including Prescription Opioids for Individuals with Chronic Pain

The Executive budget includes a number of proposals intended to address the problem of opioid abuse.¹⁹ Opioid abuse is a serious problem with real human consequences in New York as well as in many other parts of the country. At the same time, however, opioids are still an important and necessary component of pain management for many people who experience chronic pain, the majority of whom do not abuse or become dependent on them.²⁰ For people with chronic pain, the

¹⁶ HMH Part D §§ 4 & 5.

¹⁷ HMH Part D §§ 2 & 3.

¹⁸ 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).

¹⁹ HMH Part D §§ 6 & 7

²⁰ "Rates of opioid abuse or dependence diagnosis ranged from 0.7% with lower-dose (≤ 36 MME) chronic therapy to 6.1% with higher-dose (≥ 120 MME) chronic therapy, versus 0.004% with no opioids prescribed. Ten fair-quality uncontrolled studies reported estimates of opioid abuse, addiction, and related outcomes. In primary care settings, prevalence of opioid dependence (using DSM-IV criteria) ranged from 3% to 26%. In pain clinic settings, prevalence of addiction ranged

lack of access to effective pain management – which for some people includes opioids – can cause patients to seek dangerous forms of self-help, such as heroin or street fentanyl, or to fall into hopelessness, despair, and suicide.²¹ The human cost of preventing people with chronic pain from getting the pain management they need is also great. While we acknowledge the need to address the opioid abuse crisis, we have several specific concerns about some of the proposals in the executive budget:

The Governor has proposed to advance legislation to limit opioid prescription refills to seven days before an in-person visit with the prescriber must take place.²² This proposal will prevent people from receiving effective pain management, particularly New Yorkers with mobility disabilities, New Yorkers who may not have reliable access to transportation, and New Yorkers in rural areas, where in-person prescriber visits may not be available every fourteen days.

The Executive proposes to change the prescription drug formulary to impose significant burdens on prescribers of opioids.²³ Prescribers already face increasing civil and criminal scrutiny for prescribing opioids for pain management. These prescribers may decide that it is not worth risking their license, livelihood, and liberty to prescribe these medications even when they are most needed.

The proposal to allow voluntary comprehensive medication management raises real due process and substantive concerns.²⁴ This proposal enables a pharmacist to change dose, administration, or frequency of a patient's prescription. This raises due process concerns because these changes should trigger an appealable notice of denial, and substantive concerns because nonconsensual reductions in pain management opioids can drive people in chronic pain to seek relief by means of illicit drugs or by taking their own life to end the pain.

We urge the Legislature and the Governor to carefully balance the very real need for pain management including opioid use as the State addresses the opioid abuse issue.

Recommendation: Preserve the right of MLTC plans to contract with as many LHCSAs as are necessary to serve their members.

The Governor has proposed an administrative policy change to limit to ten the number of Licensed Home Care Services Agencies with which an MLTC plan can contract. We oppose this proposal,

from 2% to 14%." Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1–49. DOI: <http://dx.doi.org/10.15585/mmwr.rr6501e1>

²¹ Stefan G. Kertesz, M.D., Adam J. Gordon, M.D., and Sally L. Satel, M.D., "Opioid Prescription Control: When The Corrective Goes Too Far", Health Affairs Blog, January 19, 2018, at <https://www.healthaffairs.org/doi/10.1377/hblog20180117.832392/full> see also Lynn R. Webster, M.D., "Pain and Suicide: The Other Side of the Opioid Story", Pain Medicine, 2014, 15:345-346; see also Thomas Kline, M.D., PhD., "Suicides: Associated with non-consented Opioid Pain Medication Reductions 2015-2018", available at <https://medium.com/@ThomasKlineMD/suicides-associated-with-non-consented-opioid-pain-medication-reductions-356b4ef7e02a>.

²² Excelsior – Ever Upward: 2018 State of the State, page 241

²³ HMM Part D § 7.

²⁴ HMM Part D § 6.

because it will limit choice for consumers and disrupt long established relationships between home care providers and consumers. In many communities, managed care plans need to contract with much more than 10 LHCSAs to meet the needs of their consumers in terms of language, culture, social and other characteristics. In addition, MLTC plans which operate statewide or across a large part of the state will likely be unable to operate under this cap.

Recommendation: Preserve the right of consumers to make informed decisions about long term services.

The Governor has proposed an administrative policy change to prevent community based providers of long-term services and supports from marketing their services. We oppose this proposal. Medicaid recipients in need of long term care must be able to learn about the community-based services to which they are entitled. Particularly for consumer Directed Personal Assistance, which is still a relatively unknown benefit, the cut would amount to a backdoor benefit cut, eliminating a program by ensuring those who could benefit are unaware of its existence. In addition, by targeting community-based providers for this advertising ban, this proposal further undermines the integration mandate of the Governor's *Olmstead* plan and the rights of disabled people and seniors.

Oppose Changes in Eligibility Requirements That Create Barriers to Necessary Care

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

We strongly oppose the Executive Budget's proposed changes to the spousal and parental refusal provisions.²⁵ The protections currently available 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's proposal would substantially limit the longstanding right to utilize spousal refusal for community Medicaid eligibility, and would also abolish parental refusal which allows disabled and chronically ill 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 not enrolled in MLTC or a waiver 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, including homecare for some people, should the legislature adopt the proposal to restrict the right of spousal or parental refusal.

²⁵ HMM Part B § 6.

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 copays, 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.

Recommendation: Instead of lowering spousal impoverishment resource limits, which hurt couples with fewer resources, the State should set that limit to the Federal maximum allowed.

Spousal impoverishment protections allow the spouses of people on Medicaid in nursing homes, waiver programs and MLTC to retain sufficient income and resources to prevent them from ending up in poverty and on Medicaid themselves. Those who benefit from spousal impoverishment are usually on fixed incomes, using their income and spending down their own resources to pay their cost of living expenses, including their own medical bills.

More than twenty years ago, New York set the spousal resource allowance at \$74,820, an amount that has never been adjusted for inflation. This year, the Governor is proposing to reduce the spousal resource allowance by more than \$50,000 to \$ 24,180.²⁶ This is less than \$2,000 above the regular Medicaid resource limit for a couple. The Legislature should reject this proposal, as it did in the FY2017 Budget, and instead increase the allowance to the current federal maximum, \$123,600.

Under federal law, the community spouse (the spouse who is not receiving long term care or waiver services) can keep the greater of:

1. The federal minimum resource allowance (\$24,180), or the resource allowance set by the state – currently \$74,820 in New York – whichever is higher, or
2. One-half of the couple's combined assets, up to \$123,600 (2018).²⁷

Because of this formula, a community spouse whose assets are below approximately \$150,000 will have to give up more of their assets under the Governor's proposed reduction, while a community

²⁶ HMH Part B § 7.

²⁷ 42 U.S.C. § 1395(2)(A).

spouse whose assets exceed that amount will continue to be able to retain half of the combined assets.

In short, this proposal will only hurt those who need spousal impoverishment protections the most – couples with more moderate resources. It will not affect those with higher resources. Rather than hasten the impoverishment of people with a spouse who is sick or disabled, the State should acknowledge the tremendously increased cost of living and medical costs in New York since 1996 and increase the spousal impoverishment allowance to the federal maximum, allowing that amount to adjust for inflation.

Recommendation: Oppose the Governor’s proposal to require a UAS-NY score of nine or higher, and 120 consecutive days needing community-based services, in order to receive long term community based services through MLTC.

Empire Justice Center opposes the Governor’s proposal to require a score of nine or higher on New York’s Uniform Assessment System (UAS-NY), as well as a consecutive 120 days of need for community based long term services and supports, as a condition of eligibility for MLTC.²⁸ 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 anticipates that additional individuals who are currently MLTC eligible no longer will be. The vast majority of these individuals will be dually eligible (people on Medicaid and Medicare) who require more than 120 days of level II personal care services, but who do not score at least a nine on the UAS-NY. Dually eligible people are excluded from enrolling in MMC plans, and will default to the LDSSs. But with the roll out of mandatory MLTC statewide now complete, many LDSSs have severely reduced resources available in their home care programs, and struggle to provide services to those for whom they still retain responsibility.²⁹

The Governor’s proposal would add a higher and more complex homecare caseload to the already under-resourced LDSSs without providing additional resources to serve this new population. In addition, this proposal will have the effect of walking back the Governor’s signature health policy of “Care Management for all” for this population.

In addition, the individuals that will no longer be eligible for MLTC under the proposal will be those using 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.

²⁸ HMH Part B § 3.

²⁹ LDSSs 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.

MLTC, by contrast, allows couples to use spousal impoverishment protections, which means that the spouse in need of care can get that care without impoverishing their family 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.

Finally, individuals receiving services through the Traumatic Brain Injury (TBI) and Nursing Home Transition and Diversion (NHTD) waivers, whose carve-in to MLTC the Department of Health has been planning, will face increased challenges in access to care. Individuals can qualify for these two waivers with a UAS score of five or higher. As those waivers transition into managed care, waiver enrollees with UAS scores below nine will likely have great difficulty setting up and maintaining the services they require in MMC (for enrollees not also on Medicare), or through the LDSSs (for dually eligible enrollees). During the TBI and NHTD waiver transition workgroup meetings, consumer advocates and providers have shown that TBI and NHTD waiver enrollees require a significantly higher level of care management and/or service coordination than is available even from many MLTC plans despite sometimes scoring relatively low on assessment instruments, including the UAS. MMC is meant to provide a significantly lower degree of care management than MLTC. And fee-for-service Medicaid currently does not have a care management system for this population outside of the waivers. Finally, many members of these waivers have disabilities that manifest with different levels of acuity on different days and at different times of day, but who will, without community based services being available when needed, be forced into institutions. This proposal has the potential to do great harm to many waiver enrollees when the waivers are transitioned into managed care.

Recommendation: Protect consumers’ ability to choose their MLTC plans.

The Executive proposes to remove from MLTC enrollees the ability to change MLTC plans and instead lock them into one plan after 30 days of enrollment if they chose the plan, and 45 days if they were assigned to the plan.³⁰ We oppose this change, as it interferes with an enrollee’s crucial ability to “vote with their feet,” and choose a different plan than one with which they are unhappy.

The MLTC contract only requires plans to assess a member’s needs by the 30th day of enrollment. This means that an enrollee may not even have received an initial plan of care from the plan by the 30th or 45th day of enrollment, so they do not even have critical information needed to decide whether to stay or switch. If the MLTC program is to satisfy the triple aim of Managed Care, it must enable consumers to choose between plans. Competition between plans to attract consumers by offering higher quality care or customer service should be encouraged rather than quashed.

Recommendation: protect MLTC enrollees’ enrollment during the initial time when their MLTC services are being put into place.

The Governor also proposes an administrative change in policy which would cause MLTC enrollees who have not received personal care or home health aide services in the first 30 days after enrollment to be disenrolled. We oppose this for several reasons.

³⁰ HMH Part B § 2.

First, as noted in the section regarding the personal care shortage above, plans, especially in upstate counties, have been known not to provide home care services for months, claiming they cannot find a home care provider who can staff a case. Rather than disenrolling the member, the state should enforce the plan's obligation to maintain an adequate network of providers.

Second, as noted in the section above opposing MLTC "lock-in", plans are not required to conduct the initial assessment until the 30th day after enrollment. Many new members will not have services started until after 30 days.

Third, this proposal can be used by plans as a pretext to disenroll high-need members, in order to avoid the high cost of their home care. By delaying the start of services, plans can cause high-needs members to be disenrolled from MLTC.

While advocates understand that the Executive does not want to pay the monthly capitation rate for a month in which the plan fails to provide home care this proposal burdens the MLTC enrollee for problems within the control and responsibility of the plan. The State should instead burden the plans with these problems, for instance by clawing back payment to the plans for the period in question, rather than disenrolling the member, and further delaying their access to home care.

Recommendation: Raise the age limit for Child Health Plus to 29, allowing all young adult New Yorkers, including DREAMers, to have affordable 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 up to age 29 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 immigrants without legal status who were brought to this country by their parents, known as "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 2018-19 are estimated to be \$83 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.

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

For more information:

Adam Prizio, Health Law & Policy Attorney

aprizio@empirejustice.org

(518) 935-2857