32

Empire Justice Center

Making the law work for all New Yorkers

Albany ◆ Rochester ◆ Westchester ◆ Long Island

# New York State Legislature
# 2016-2017 Joint Budget Hearing:
# Health/Medicaid

**January 25, 2016**

**Prepared and Presented by:**
**Amy E. Lowenstein, Senior Attorney**

119 Washington Avenue, Albany, NY 12210
Phone 518.462.6831 ◆ Fax 518.935.2852
www.empirejustice.org

## Introduction

My name is Amy Lowenstein and I am a Senior Attorney in the Albany office of Empire Justice Center. I'd like to thank you for the opportunity to testify today concerning the 2016-2017 Health and Medicaid Budget.

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

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

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

1. Expand and strengthen post-enrollment health insurance advocacy and assistance for New Yorkers by supporting the Governor's appropriation for Community Health Advocates (CHA) with an additional legislative investment of $1.5 million.

2. Provide $10.3 million in state funding to expand the Basic Health Program to all income eligible immigrants who are permanently residing under color of law.

3. Ensure that sick and disabled children, New Yorkers with disabilities, and seniors continue to have access to medically necessary care by preserving spousal and parental refusal in the Medicaid program.

4. Enhance spousal impoverishment protections for individuals whose spouse is in a nursing home, managed long term care or Medicaid waiver program.

5. Ensure that New York's most vulnerable Medicaid recipients are able to access the medications prescribed by their doctors by preserving prescriber prevails in Medicaid's fee-for-service and managed care programs.

6. Address barriers to accessing homecare and other community based long term care by taking steps to deal with the Medicaid personal care aide shortage and increase oversight and accountability of Medicaid managed care plans, including MLTC.

7. Ensure that changes in MLTC eligibility rules do not result in additional barriers to homecare.

8. Ensure that dually eligible (Medicare and Medicaid) beneficiaries are able to find providers to treat and serve them by rejecting the proposed reduction in the Medicaid reimbursement rate for Medicare Advantage coinsurance.

9. Restore access to medically necessary physical, occupational, and speech therapies by repealing Medicaid's 20 visit hard cap on those services.

## Support Community Health Advocates (CHA)

**Recommendation:** Provide an additional $1.5 million for a total investment of $4 million for Community Health Advocates (CHA).

We appreciate the Governor's continued support for Community Health Advocates (CHA) through the $2.5 million allocation for CHA in the Executive Budget. However, we are asking the Legislature once again to provide additional funds for CHA to bring it to its current annualized budget of $4 million. This will allow the program to continue providing the same level of services. Without this investment CHA faces a 25% cut in funding.

Community Health Advocates is a statewide network of community based organizations, including chambers of commerce, that assist individuals and small employers in New York so that they are able to effectively use health insurance coverage and access quality health care. The services CHA provides are critical. The success of the New York State of Health Marketplace depends on the ability of individuals to not only enroll in, but to be able to use their health coverage.

The health care system is notoriously challenging to navigate. Most consumers have difficulty grasping even basic terms associated with health insurance coverage such as premiums, co-insurance and co-pays. Understanding how to utilize health insurance coverage to access care, particularly when the insurer places restrictions on that care, is even more difficult.

CHA focuses on assisting individuals who encounter problems once they have enrolled in health insurance. CHA is administered by the Community Service Society of New York and consists of a statewide network of 30 community based organizations and specialists offering

services ranging from community outreach and education to appeals of service denials. CHA also operates a live-answer, toll-free consumer hotline and supports efforts to improve the health care system by analyzing trends in its statewide database and providing valuable feedback to policy makers.

Since November 2010, the CHA program has helped approximately 213,000 individuals understand, navigate and keep their health coverage and access health care, saving nearly $15 million in health related and health insurance costs for consumers across the state. CHA provides critical assistance to all New Yorkers, regardless of insurance coverage type, including commercial insurance available through the Marketplace, employer coverage, and public insurance products, like Medicaid and Child Health Plus.

Originally funded through federal Consumer Assistance Program and Exchange grants, CHA at its height, was a $6.1 million program with more than double its current number of local community based groups. In 2015, nationally, federal funding for programs like CHA dried up. The Governor and the Legislature stepped in to support CHA in the 2015-2016 Enacted Budget with state funding totaling $3 million. The Assembly Majority provided $500,000 of that funding, for which we are incredibly grateful. Ultimately, due to the need to shift CHA from a federal to a state fiscal year, this funding had to be used in nine months, resulting in an annualized CHA budget of $4 million.

This year, Empire Justice Center and our colleagues are asking the Legislature to increase its support for CHA to $1.5 million, building on the $2.5 million in the Executive Budget. This level of legislative investment will allow CHA to continue at a total of $4 million so it can retain the program and network at its current levels and avoid a 25% funding cut statewide.

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

## Expand the Essential Plan for all PRUCOL[1] Immigrants

**Recommendation:** Expand the Essential Plan to cover all income eligible PRUCOL immigrants.

The Basic Health Plan – now renamed the Essential Plan (EP) – which officially launched on January 1st, is a huge step forward in making health insurance much more affordable for people who are just above the Medicaid income eligibility threshold. At a cost of $20 or less per month, this program will make an enormous difference to low income New Yorkers who, even with federal subsidies and cost sharing assistance, previously could not afford health insurance.

While the Essential Plan promises affordable health insurance to many low income New Yorkers, some New Yorkers – a subset of Permanently Residing Under Color of Law

[1] Permanently Residing Under Color of Law. All PRUCOL immigrants are present in the United States with the knowledge and permission or acquiescence of Homeland Security.

(PRUCOL) immigrants, including those with deferred action for childhood arrivals (DACA) status – are left without any viable health coverage options except state-funded Medicaid. If these individuals have income above the Medicaid level they experience a health insurance cliff. They are excluded from the Essential Plan and other Marketplace products under federal rules, leaving them with no affordable insurance options and forcing them to forego treatment or seek care from hospitals where they are able to receive "charity care."

We urge the Legislature to ensure access to health insurance for this population, estimated at about 5,500 people, primarily young adults, by allocating $10.3 million for a state-funded Essential Plan.

## Preserve Spousal and Parental Refusal

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

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

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

Situations continue to arise where parental or spousal refusal is necessary to ensure access to medical care. For example, we advised spousal refusal where a woman with Multiple Sclerosis (MS) on Social Security Disability faced drug costs of between $900 and $6,000 per month, depending on whether she was in the doughnut hole or catastrophic coverage phases of her Part D plan. With a spousal refusal, she could get into the Medicare Savings Program and, thereby, get Extra Help paying for her Part D drugs, making a prohibitively expensive drug affordable at $6.60 per month and allowing her to receive appropriate treatment for her MS. We also recommended parental refusal to the working mother of a severely disabled child who was erroneously denied Medicaid waiver services that would have disregarded the mother's income. A government official suggested that the mother quit her job in order to get

Medicaid services for her child. Parental refusal permits the mother to keep her job while challenging the waiver denial.

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

## Enhance Spousal Impoverishment Protections

**Recommendation:** Increase rather than reduce the spousal impoverishment resource allowance.

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 $23,840, an amount that is only $2,000 above the regular Medicaid resource limit for a couple. The Legislature should reject this proposal and instead increase the allowance to the current federal maximum, $119,220.[2]

Spousal impoverishment protections allow spouses of people in nursing homes, waiver programs and Managed Long Term Care 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 relying on their own resources to pay their cost of living expenses, including their own medical bills.

Under federal law the well spouse can keep the greater of:

1. The federal minimum resource allowance, 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 $119,220 (2016).[3]

The Governor's proposal would reduce the amount set by the state from $74,820 to the federal minimum, $23,844. As illustrated in the table below, the proposal will hurt couples with more moderate resources. It will not affect those with higher resources.

---

[2] 2016 SSI and Spousal Impoverishment Standards. Available at https://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/downloads/2016-ssi-and-spousal-impoverishment-standards.pdf (last visited 1/23/16).

[3] 42 U.S.C. § 1395(2)(A).

| | Maximum Amount of Assets Community Spouse May Keep[4] | | |
|---|---|---|---|
| Couple's Combined Assets | Under Current NY Law | **Under Governor's Proposed Change** | If allowance raised to the federal maximum[5] |
| $30,000 | $30,000 | **$23,840** | $30,000 |
| $47,680 | $47,680 | **$23.840** | $47,680 |
| $74,820 | $74,820 | **$37,410** | $74,820 |
| $100,000 | $74,820 | **$50,000** | $100,000 |
| $119,220 | $74,820 | **$59,610** | $119,220 |
| $140,000 | $74,820 | **$70,000** | $119,220 |
| $149,640 | $74,820 | **$74,820** | $119,220 |
| $238,440 | $119,220 | **$119,220** | $119,220 |
| $350,000 | $119,220 | **$119,220** | $119,220 |

New York already has a situation where couples with more resources have a higher resource allowance than those with lower resources. For example, while Couple A that has resources of $119,220 may keep $74,820, Couple B with resources of $250,000 gets to keep $119,220. The budget proposal will only widen this disparity, deriving savings from lower resourced couples, as, for example, a couple who today can retain assets of $47,680 will only be able to retain half of that, $23,840. As a result, community spouses who rely on their resources to pay their expenses will find themselves with insufficient resources to stave off impoverishment and their own need to turn to Medicaid for help with healthcare costs.

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 1995 and increase the spousal impoverishment allowance to the federal maximum, allowing that amount to adjust for inflation.

## Retain Prescriber Prevails

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

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

[4] This table is based on a table created by New York Legal Assistance Group.

[5] As of 2010, 18 States used the federal maximum. "Access to Long-Term Services and Supports: A 50-State Survey of Medicaid Financial Eligibility Standards," AARP, Public Policy Institute (2010), pp. 22-23. Available at http://assets.aarp.org/rgcenter/ppi/ltc/i44-access-ltss_revised.pdf (last visited 1/23/16).

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 the State should not seek to save money on the backs of the most medically needy New Yorkers.

## Address Barriers to Accessing Community Based Long Term Care Services

**Recommendation:** Take steps to deal with the Medicaid personal care aide shortage and increase oversight and accountability of Medicaid managed care plans, including MLTC.

At a time when the State has expressed its commitment to the goal of supporting individuals with disabilities living in the most integrated setting, it is critical that the community-based long term services and supports, including homecare, necessary to achieve this goal are available and provided.

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

- A shortage of personal care aides, particularly upstate. The upstate aide shortage has left individuals in need of personal care services stuck in nursing homes, unnecessarily hospitalized, or putting their health and safety at risk at home without sufficient aide services. We have repeatedly heard from advocates and individuals that local districts and managed care plans are not able to fill approved hours because there are no aides available in a rural area or because an enrollee does not live on a bus line. Now that aides are finally covered by the Fair Labor Standards Act's overtime and travel requirements, the aide shortage has intensified. Personal care providers are capping aide hours to avoid the requirements, resulting in further reduction of the available workforce.
- Managed care plans are discouraging people with higher needs from enrolling in their plans by offering hours that are insufficient to allow an individual to live in their home, requiring people to have a family caregiver as "backup" support, telling people their

needs are too high before conducting an assessment, and telling people who may need 24-hour care that they do not provide that level of care.

- Widespread reductions in personal care service hours by managed care companies are occurring. Almost always it seems that the justifications for these reductions are insufficient and, if taken to a hearing, the Medicaid recipient usually wins. However, the cuts in hours continue, presumably in the hope that many enrollees will not bother to appeal or will agree to negotiate for a smaller reduction in hours, but fewer hours than they would win at a hearing.
- Some managed care companies are actually refusing to comply with fair hearing decisions.

We understand the challenge in finding solutions to these and other barriers to accessing community based services. However, we suggest the following:

- Strengthen the community-based long term care workforce and address the workforce shortage by ensuring adequate competitive wages and benefits.
- Provide the necessary funding to pay for the new overtime and travel requirements as well as an increased minimum wage. This includes providing managed care capitation rates that are sufficient to account for increased costs and requiring that any increased capitation rate be used to increase the availability of aide services.
- 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. 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_2014.pdf).

## Ensure that Changes in MLTC Eligibility Requirements Do Not Create Additional Barriers to Care

**Recommendation:** If the legislature adopts the proposal to require a nursing home level of care as a condition of Managed Long Term Care eligibility, ensure that Local Departments of Social Services have the necessary resources to cover services.

Empire Justice Center urges caution in considering the Governor's proposal to add a nursing home level of care requirement as a condition of eligibility for Managed Long Term Care (MLTC). While there have been notable challenges in accessing care through MLTC, we are

concerned that those who will no longer be eligible for MLTC under the proposal will have difficulty accessing the services they require. The proposal should therefore only be adopted if sufficient resources outside of MLTC are available through the counties and New York City to provide services to the people who will newly be excluded from MLTC.

By adding the nursing home level of care requirement, the Executive Budget clearly anticipates that additional individuals who are currently MLTC eligible no longer will be. While it is not clear who this population is – the nursing home level of care threshold is quite low – it presumably includes dually eligible Medicaid and Medicare recipients who need certain level II personal care services for more than 120 days. The duty to provide these services will fall to the Local Departments of Social Services. However, with the roll out of mandatory MLTC statewide now complete, many local districts have severely reduced resources available in their home care programs, and already struggle to provide services to those for whom they still retain responsibility.[6] At least one county has noted that it no longer has nurses to assess people for personal care, allegedly because providers are no longer willing to take the low reimbursement rate when better rates are available from MLTCs. Another county, until recently, erroneously believed it no longer had to provide personal care services other than housekeeping and was therefore unable to fill the 49 hours of personal care needed by a person who was exempt from MLTC and MMC enrollment.

Because the already under-resourced local districts would be picking up a higher and more complex homecare caseload under the Governor's proposal, it is essential that resources to serve this new population, as well as existing populations, are provided to the local districts in conjunction with the proposal.

## Preserve Medicaid Reimbursement Rates to Medicare Advantage Plan Providers

**Recommendation:** To prevent the further erosion of the number of providers who will treat or provide services to dually eligible individuals, the Legislature should reject the Governor's proposal on Medicaid reimbursement of Medicare Advantage co-insurance.

We oppose the Executive Budget proposal to reduce Medicaid reimbursement to providers who treat individuals dually eligible for Medicare and Medicaid. The proposal would cap the amount Medicaid contributes towards a Medicare Advantages coinsurance or copay so that the total reimbursement the provider receives from both the Medicare Advantage plan and Medicaid is no higher than the total Medicaid would have paid for the service. This proposal will only exacerbate the challenges dually eligible individuals have finding providers willing to provide services to them.

[6] 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.

For years, we have received numerous calls regarding dually eligible individuals who are being balance billed for services received from a Medicare provider. Many of these dual eligibles are Qualified Medicare Beneficiaries (QMBs) – their Part B premiums, and Medicare deductibles and coinsurance are covered by Medicaid. Under federal rules, QMBs may not be balance billed for Medicare or Medicare Advantage co-insurance or copays even by providers who do not accept Medicaid generally. Nevertheless, providers continue to balance bill QMBs, and when they learn that is impermissible, some simply refuse to continue to see QMB patients.

The consequences for dually eligible clients are real. Last year, the enacted budget reduced the Medicaid reimbursement for the Medicare Part B coinsurance in the same manner that is now proposed with respect to Medicare Advantage coinsurance. As a direct result of that change in reimbursement, a chain pharmacy and Medicaid provider has informed one of our dually eligible clients that it will have to start charging him the $60-70 co-insurance for his Medicare Part B medications. While we are educating the provider on the prohibition on balance billing, we also are mindful that the pharmacy may decide to simply no longer fill our client's prescriptions.

To prevent the further erosion of the number of providers who will treat or provide services to dually eligible individuals, the Legislature should reject the Governor's proposal on Medicaid reimbursement of Medicare Advantage co-insurance.

## Remove Medicaid Physical, Occupational & Speech Therapy Visit Caps

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

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

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

- A 28 year old single working mother with a degenerative disc disease; spinal stenos; arthritis in her back, knees and feet; nerve and muscle damage; and a number of other conditions needs regular physical therapy to maintain her current functioning. Prior to receiving Medicaid three years ago, her health insurance paid for regular physical therapy. However, each year since receiving Medicaid, she has used up the 20 visit Medicaid physical therapy benefit and then been forced to wait months until the next plan year to start her critical therapies again. Each year, in the interim, her condition declines, so that when she is again authorized for physical therapy she must first

rehabilitate from the time without treatment and then work on maintenance again. In 2015, she underwent spinal surgery, after which she was only approved by her Medicaid managed care plan to receive three physical therapy sessions, because she had used her other physical therapy visits prior to the surgery. She has been unable to recover from the surgery and for months now has had increased difficulty performing simple tasks like bathing, walking, sitting, standing, and using stairs.

- A man who received physical therapy after shoulder surgery was denied any physical therapy to recover from ankle surgery he had several months later.[7]
- At a hearing, the Administrative Law Judge remarked about a student, "there is little doubt that additional physical therapy would be beneficial to her," and then denied additional physical therapy at her hearing despite experiencing increased pain and difficulty walking, trouble sleeping, and difficulty climbing the stairs to her home.[8]
- A 52 year old three-quarter house resident suffered a stroke for which he needed more than 20 speech therapy sessions to improve his functioning was denied additional therapy.[9]

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

Medicare places an annual dollar limit on the three therapies, but, critically, provides for an exceptions process that allows coverage beyond the dollar limit where additional therapies are medically necessary.[10]

As part of the required essential health benefits in New York, small group and individual health insurance plans, including QHPs and the Essential Plan, currently have a 60 visit per condition per lifetime cap on rehabilitative physical, occupational, and speech therapies, and an additional 60 visit per condition per lifetime habilitative services benefit for the three therapies.[11] Habilitative services include therapies to maintain or prevent deterioration in functioning. In 2017, these plans will shift to a 60 visit per year cap for each of the three therapies, and an additional coextensive benefit for such therapies received as habilitative

---

[7] Decision After Fair Hearing, FH# 7152875L, Jan. 6, 2016. Available at http://otda.ny.gov/fair%20hearing%20images/2016-1/Redacted_7152875L.pdf (last visited 1/21/16)

[8] Decision After Fair Hearing, FH# 7147874P, Nov. 18, 2015. Available at http://otda.ny.gov/fair%20hearing%20images/2015-11/Redacted_7147874P.pdf (last visited 1/21/16)

[9] FH#7064574H, Decision After Fair Hearing, Sep. 18, 2015. Available at http://otda.ny.gov/fair%20hearing%20images/2015-9/Redacted_7064574H.pdf (last visited 1/21/16)

[10] 42 U.S.C. § 1396r-5l(g).

[11] New York EHB Benchmark Plan 2014-2016, p. 4. Available at https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Updated-New-York-Benchmark-Summary.pdf (last visited 1/21/16)

services.[12] Notably, of the ten 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.[13]

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

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

**For more information:**
Amy E. Lowenstein, Senior Attorney
alowenstein@empirejustice.org
(518) 935-2857

[12] New York 2017 EHB Benchmark Plan, p. 3. Available at https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/NY-BMP.zip (last visited 1/21/16

[13] 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 (last visited 1/21/16)