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**Medicaid Redesign Team
New York City Hearing
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Testimony of The Legal Aid Society

Introduction

Thank you for the opportunity to testify today. My name is Lisa Sbrana and I am the Supervising Attorney for The Legal Aid Society's Health Law Unit.

The Legal Aid Society provides crucial criminal, juvenile rights and civil legal assistance to low income families and individuals in every community in the five boroughs of New York City. During the past year, The Legal Aid Society provided criminal, juvenile rights and civil legal services in more than 300,000 cases and legal matters for New Yorkers in desperate need of legal help. Many of these clients are referred to The Legal Aid Society by the constituent services staffs of State elected officials or by community-based organizations serving every district of the City.

The Health Law Unit operates a statewide health law helpline for consumers and advocates. We represent public health insurance applicants and recipients as they attempt to navigate the application and enrollment process and once enrolled we provide assistance accessing medically necessary care. Our Unit is also a specialist organization with New York's new Consumer Assistance Program funded under the Patient Protection and Affordable Care Act (ACA) where we provide technical assistance and training to community based organizations and accept client referrals. Members of our Unit serve on the Medicaid Managed Care Advisory Review Panel (MMCARP), the Medical Advisory Committee (MAC), and the steering committee of Medicaid Matters New York. We also lead Medicaid Matters New York's Managed Care Workgroup.

We would like to thank Governor Cuomo, Commissioner Shah, Medicaid Director Helgeson and the Medicaid Redesign Team (MRT) for their commitment to this process, opening the discussion to a diverse group of stakeholders in the Medicaid

program and to transparency in the process as difficult decisions are made on how to engage in constructive changes to the program. We are encouraged by the discussions so far and the commitment that has been expressed to reducing costs while improving access and quality.

Many of you have read or heard the buzz around the January 24th article in the New Yorker by Atul Gawande. The article excited many who advocate on health access issues. Some imaginations were piqued by the use of data; mapping “The Hot Spotters”, as the article is entitled, to find high-density areas of expensive users of the health care system. Others are intrigued by the idea of reducing costs while increasing access, quality and the range of medical and social services provided. What captured my imagination was the idea of a health care system that meets patients where they are. Treating them as the individuals we know them to be, rather than as aggregate numbers in a database. It was exciting to read about targeted coordination of health care services with other social services to provide comprehensive interventions.

Service Delivery

The Gawande article is perfectly timed for our discussion. It focuses on difficulties individuals with chronic multiple health conditions and unstable living conditions have accessing appropriate health care services. It also offers hope that individualized coordinated treatment plans can greatly reduce health care expenses. We are at a cross-roads – New York has a proud tradition of providing comprehensive health care services to its most vulnerable citizens. It is clear that changes need to be made to reduce costs and inefficiencies and to improve access and quality for many Medicaid recipients.

Enrolling more people in managed care and/or eliminating current managed care benefits package carve-outs has been one of the solutions offered. Although this may sound like a logical cost-saving measure, it important to compare it with all of the principles with which this team has been charged. While costs may be reduced, improved access and quality will only be achieved by ensuring provider accountability. The current contracts with managed care plans are unenforceable by beneficiaries. In fact, third parties are explicitly prohibited from enforcing the contract, which means that the Department of Health must enforce compliance of the contract terms. The Department is currently operating with a skeletal crew. Any expansion of managed care should include beneficiary enforcement rights and provide for a corresponding increase in Department staff to oversee contracts and compliance.

The adoption of comprehensive care coordination models provides both the opportunity to receive increased federal matching funds and for realizing savings based on better health outcomes. While we support initiatives like Medical Homes and Health Homes which seek to provide comprehensive primary and specialty

care coordination to consumers, we urge the MRT to recommend that any plans to adopt such measures include requirements that the Department have the staffing necessary to enforce contract terms and monitor compliance, quality outcomes and data collection.

If managed care on its own or in conjunction with Medical Homes and/or Health Homes is the vehicle chosen to improve health outcomes and provide cost-savings for the Medicaid program, then clear standards for how that care will be delivered must be developed with input from consumer advocates. Standards should include defining methods for delivering care coordination and measuring access and quality along with implementation and compliance plans. It is critical that this process be transparent and inclusive with opportunities to review and comment on proposals while they are in draft form. Advisory committees like the MMCARP and MAC should be utilized fully as means of engaging stakeholders in the process.

Interestingly when investigating how New York could provide a Camden-style health access intervention like that described in Mr. Gawande's article, one patient centered delivery model recommended to me was HIV Special Needs Plans for HIV positive Medicaid Managed Care enrollees. The HIV SNPs provide a comprehensive benefits package that includes coordination of medical services and assistance accessing social services like housing and public benefits which support wellness. A 2009 Lewin Group study comparing utilization data with HIV SNP enrollees and HIV+ fee-for-service recipients found increased utilization by SNP enrollees of appropriate health care services, but lower overall costs for providing coverage. Any discussion of expanding managed care to individuals with complex health conditions and lives requires a commitment to comprehensive service provision like that of the SNPs.

Finally, for an expansion of managed care to meet the MRT mandates of improving access and quality, there must be a commitment to staff the Department at levels that allow for improving accountability, transparency and oversight of the program.

Access to Coverage

It is critical that New York act quickly this session to enact legislation establishing a Health Insurance Exchange as required by the ACA. Medicaid should be the foundation New York builds on as part of the continuum of health insurance options under the Exchange. Similarly, we must build on the simplification and streamlining measures that the Medicaid program has adopted in the past four years. The ACA mandates a consumer friendly "no wrong door" approach to accessing coverage. Applications must be accepted in person, by phone, by mail and electronically for public health insurance coverage and subsidies offered in the Exchange. An example of how this will benefit New Yorkers is that applicants will no longer face the discouraging news that they must go to another location to submit an application for health insurance because their child is eligible for Child Health Plus not Medicaid.

Under our current system, computers running New York City's Medicaid program cannot communicate with computers running the rest of the State's local Medicaid programs or Medicaid for children in New York City's foster care system. Similarly, computers running the Medicaid program cannot speak to the Child Health Plus system making it impossible for children to be seamlessly transferred between programs. This patchwork system is beyond repair. Although an initial investment will be required, there is significant federal funding available for systems improvements. Additionally, reducing the administrative burden of administering and patching New York's current systems and eliminating the manual overrides currently required to trouble shoot the system's gaps will ultimately save money. The State should take advantage of increased federal administrative matching funds to ensure compliance with the ACA requirements and legislation adopted by New York last year designed to eliminate duplicative efforts in the administration of the Medicaid program by having the State take over the administration of the program by 2015. Again, critical to this effort is the need for the Department of Health to maintain the staff required to build this system.

Thank you again for the opportunity to testify today. Please feel free to contact me at 212-577-3394 or lbrana@legal-aid.org should you have any questions.