

Testimony of The Legal Aid Society
On
THE 2011-2012 EXECUTIVE BUDGET
TOPIC: HEALTH/MEDICAID

Submitted to:

**The Senate Finance Committee
and
The Assembly Committee on Ways and Means**



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The Legal Aid Society appreciates the opportunity to submit testimony for this hearing on funding for critical Health and Medicaid services in the 2011-2012 Executive Budget.

The Society's Health Law Unit operates a State-wide Helpline that assists New Yorkers in need of health care services or health insurance coverage, and those mired in medical debt. As the economy has worsened, the number of calls to our helpline has increased steadily. In addition to providing direct client assistance, our unit provides technical assistance and training to advocates throughout the State. We serve on the steering committees of coalitions raising beneficiaries' concerns including Medicaid Matters New York and the Statewide Consumer Coalition on Medicare Part D. We also participate in workgroups on Medicaid streamlining and simplification, Medicaid managed care, and Charity Care.

Legal Aid's Juvenile Rights Practice provides comprehensive legal representation to children who appear before the New York City Family Courts in all five boroughs, in abuse, neglect, juvenile delinquency, and other proceedings affecting children's rights and welfare. Last year, our Juvenile Rights staff represented some 34,000 children. In addition to representing many thousands of children each year in trial and appellate courts, Legal Aid also pursues impact litigation and other law reform advocacy on behalf of our clients.

The Legal Aid Society recognizes the gravity of the fiscal crisis facing our State and we greatly appreciate the commitment on the part of the Governor and the Legislature to maintain, and where possible to increase, access to both health insurance and health care services. We submit this testimony to alert you to several proposals raised through the Medicaid Redesign Team (MRT) process and introduced in the 30 day amendments to the Executive budget that we support because they remove barriers and increase access to health care. We are also here today to highlight our concerns with the MRT process and regarding proposals in the Governor's amended budget that diminish access to health care coverage and services.

Improving Access to Health Care Services

In these very difficult times, when maintaining access to health care services is more difficult and important than ever, the Executive budget proposes the removal of several important barriers to accessing Medicaid and health care services for low-income New Yorkers. We applaud the Governor for including the following proposals in his 30 day amendments.

- Establishment of the Public Health Service Corps.
- Administrative Renewal for Elderly and Disabled.
- Disregarding retirement assets for individuals in the Medicaid Buy-in for Working People with Disabilities program.
- Improving access to supportive housing.
- Linking reimbursement rates to support efforts to address health disparities.
- Maximizing Peer Services

Capitalizing on federal matching funds under the Affordable Care Act

It is critical that New York adopt legislation this session to implement a Health Insurance Exchange as required under the Affordable Care Act. New York is a leader State and its commitment to the provision of public health insurance and quality health care service has been rewarded with an Early Innovator Grant to develop the technology necessary to support the Exchange and seamless transitions between out public health insurance programs and subsidies offered through the Exchange. To ensure New York's ability to provided comprehensive coverage to low-income New Yorkers, we urge the Legislature to support the following Executive proposals which will improve care coordination and access to health coverage.

- Expanding the statewide Patient-Centered Medical Home model.
- Implementing Health Homes for High-Cost, High-Need Enrollees.
- Developing an Automated Exchange/Medicaid Eligibility System.
- Enrollment and retention simplification.

The Medicaid Redesign Team Process

While we appreciate the fiscal constraints, the difficult of the charge given to the MRT, the commitment to the program and hard work of Commissioner Shah, Medicaid Director Helgerson and Department of Health staff through out the MRT process, we would be remiss not to point out that not one of the State's 4.6 million Medicaid beneficiaries was appointed to the MRT. Similarly, while there are hundreds of consumer advocates across the State, only one was appointed to the MRT. Going forward we urge the Governor to appoint consumers and additional consumer advocates to the MRT.

Proposals limiting access to Medicaid and health care services

Pharmacy – limiting access to pharmacy benefits may save money on the front end only to increase costs on the back end when individuals denied access end up requiring more invasive and expensive interventions because conditions that could have been managed pharmacologically worsen due to reduced access to medications. We therefore urge the Governor and the Legislature to reconsider the following proposals:

- Moving pharmacy benefits from fee-for-service to managed care plans.
- Eliminating prescriber prevails provisions.
- Adding prior authorization requirements to anti-depressants, atypical anti-psychotics, anti-retrovirals and immunosuppressants.
- Eliminating Medicaid Part D wrap-around coverage.

Long-term Care Services – The U.S. Supreme Court's decision in Olmstead requires that individuals with disabilities receive health care services in the most integrated setting. The federal government offers State Medicaid programs funding alternatives in the form of waivers to achieve this goal. There are also additional incentives under the

Affordable Care Act to ensure that individuals with disabilities and chronic illnesses are able to remain in their communities. Proposals limiting access to long-term care services in the community run counter to the federal mandates. The proposals to expand the look back period for community based long term care services and eliminating spousal refusal may also violate the Maintenance of Effort requirements under the Affordable Care Act. We therefore urge the Governor and the Legislature to reconsider the following proposals:

- Mandating enrollment in Managed Long Term Care Plans for individuals with long-term Certified Home Health Aide needs.
- Apply 60 month look back period to non-institutional long-term care.
- Add personal care services to the Medicaid managed care plan benefit package.
- Reduce the cap on housekeeping services to 8 hours from 12.
- Eliminating spousal refusal.

Medicaid Managed Care - Based on the experiences of our clients, we continue to have serious concerns about the DOH's plans to expand the mandatory Medicaid managed care program. We urge the Governor and the Legislature to reconsider the proposal to eliminate all exemptions and exclusions from Medicaid managed care without also expanding consumer rights and expanding the Department's oversight capacity. Enrollees must be able to enforce contract provisions and there must be clear guidance and standards issued to the plans so that the proposed additional mandatory populations all of whom have serious health needs receive quality accessible care. Additionally, remedies must be available to enrollees when managed care plans fail to provide medically necessary services as required under the Medicaid program.

Attention to transition issues under the Department's plan for mandating additional populations is critical. Many of our clients with chronic conditions and disabilities have lost access to vital services upon their enrollment. Personal care services should not be part of the Medicaid managed care benefits package until the problems that beneficiaries are currently experiencing accessing other long term care services within the benefit package are remedied. Currently, Certified Home Health Aide (CHHA) Services are included in the managed care benefit. For Medicaid beneficiaries with chronic illnesses and disabilities who are mandatorily enrolled into Medicaid managed care plans, the inclusion of these benefits in managed care has created great hardship. Many beneficiaries who have had CHHA services in place have lost these critical services upon being mandatorily enrolled in managed care.

Although we appreciate the proposal to disregard housing costs for individuals who are willing to enroll in Managed Long Term Care (MLTC) plans, we have similar concerns about expanding this program without providing additional oversight and consumer protections. While the statistics provided at the Medicaid Redesign Team meetings indicate that spending per enrollee has remained flat while spending for personal care services per enrollee has increased, since there was no comparison of hours or services provided it is impossible to tell whether savings will be achieved or whether the MLTC plans are prepared to take on a population with very high care needs.

We urge the Governor and the Legislature to review additional information on these proposals before adopting them to ensure that consumer protections including measures to adequately review access and quality of care issues, enforcement rights and compliance plans are in place.

Elderly Pharmaceutical Insurance Coverage (EPIC)

EPIC currently provides vital protection to low-income seniors enrolled in Medicare Part D. It is no secret that navigating Medicare Part D has been difficult for enrollees across the nation. Consequently, the current EPIC program which wraps around Part D is critical to ensuring that seniors do not leave the pharmacy without their prescriptions. The Executive budget proposes to eliminate this protection by reducing EPIC to coverage in the donut hole. We urge the Governor and the Legislature to reconsider this proposal.

To prevent Medicare Part D plans from shifting costs to EPIC, the Legislature gave the EPIC program authority to file appeals of denials by Part D plans on behalf of EPIC enrollees. EPIC has won more than 50% of the appeals it has filed. Instead of eliminating EPIC's wraparound benefit, EPIC should continue to maximize Medicare Part D by recovering funds expended based on incorrect denials by the Part D plans.

Alternatively – Protect Seniors and Individuals with Disabilities, Maximize Medicare Savings Program Access

The Governor and the Legislature have an opportunity to maintain vital access to prescription medications for seniors and to expand access for individual with disabilities while maximizing federal matching funds. Currently EPIC is funded with state-only dollars and access to Part D subsidies is limited to individuals who meet the currently eligibility levels for Extra Help or those with very low-incomes that meet New York's Medicare Savings Program (MSP) eligibility levels, the highest being 135% of the federal poverty level.

New York should adopt steps taken by Washington, DC, Connecticut and Maine to maximize the protections afforded to seniors and individuals with disabilities offered by MSPs. Individuals eligible for MSPs are automatically eligible for Extra Help, the Part D subsidy funded by the federal government. This subsidy provides cost-sharing protection by eliminating annual deductibles, monthly premiums and the donut hole. It also limits co-pays to \$2.30 for generics and \$6.30 for brand name prescriptions. These limits are less than most EPIC enrollees currently pay. In addition to the increased cost-sharing protection, MSPs pay for Part B premiums so seniors would have an additional \$100 in income each month.

Savings would be achieved by eliminating the cost of administering the EPIC program with state-only funds. Cost incurred by expanding two MSPs, QMB and SLMB, would be reduced by 50% federal share. There is no cost associated with expanding QI-1 which is paid for 100% by federal funds.

Dry Appropriation for the Community Health Advocates Program

Consumer assistance is a key component of the Affordable Care Act and has been established in New York as the Community Health Advocates (CHA) program. We encourage continued support of this program through the \$5 million dry appropriation in the Governor's proposed budget. This appropriation will allow the State to direct up to \$5 million in federal funds to an existing network of community-based organizations that currently provides much needed assistance in accessing health care and insurance coverage. The CHA network is currently funded by \$2.2 million allocated to the State under the federal Affordable Care Act. Federal funds are available to continue funding for consumer assistance programs for the next three years at no cost to the State. Support for the dry appropriation will allow the State to continue providing the services without any cost to the State.

CHA is a network of 25 community-based organizations (CBOs) serving New Yorkers in need of assistance with health care or insurance coverage. The network includes three specialist agencies, The Legal Aid Society, the Medicare Rights Center and the Empire Justice Center, that serve as legal back-up for the CBOs, providing training and technical assistance to CBO staff and taking referrals for more complex cases challenging eligibility or service denials. CHA CBOs are located throughout the State in the communities where those in need of the services live and work, building on the trust and experience that only local organizations can provide. Offering assistance in a linguistically diverse and culturally sensitive manner, CHA agencies educate communities about health coverage, explain the benefits of federal health reform, and provide individual assistance to those without insurance. By connecting consumers with both public and private health insurance, CHA plays a crucial role in controlling the spiraling costs of health care. CHA agencies help consumers access insurance coverage and use it effectively so that the cost of their health care can be well managed and not become an additional drain on scarce State resources.

Children in Foster Home and Institutional Placements

Children in foster care have special health care needs due to their high prevalence of medical, dental, mental health, developmental, educational and relationship problems.¹ Youth in foster care include youth with mental health issues, youth with physical disabilities, pregnant and parenting youth, LGBT youth, immigrant youth and youth with cognitive and developmental delays. The health and/or mental problems experienced by these children often result from their experiences and the trauma associated with a high-conflict home life, sudden separation from their biological family, and placement in foster care.² For example, one study found that children in foster care exhibit post-

¹ Moira Szilagyi, *Adolescents Aging out of Foster Care and Health Care*, CW360, 2009, at 14.

² NEAL HALFON, ALEX ZEPEDA, MOIRA INKELAS, *MENTAL HEALTH SERVICES FOR CHILDREN IN FOSTER CARE* (2002), at 1.
<http://www.healthychild.ucla.edu/Publications/ChildrenFosterCare/Documents/Mental%20health%20brief%20final%20for%20distribution.pdf>

traumatic stress disorder at twice the rates of combat veterans.³ Frequent moves of the children within the placement system contribute to treatment disruptions and lack of continuity. We are concerned that the plan to require these children be enrolled in managed care programs will prevent our clients from receiving timely health and mental health services and would exacerbate these already significant problems.

In recognition of the need to help improve health care outcomes for children in foster care, the Fostering Connections to Success and Increasing Adoptions Act of 2008 included Section 205: Health Oversight and Coordination Plan.⁴ Under Section 205, State child welfare agencies are obligated to create a statewide plan designed to increase the positive health care outcomes for all children in foster care by consulting with experts, including pediatricians to ensure that the youth are properly screened, assessed, and treated. The plan must also provide for the way updates to the child's condition will be recorded and shared, how the use of prescription medications will be monitored, and how continuity in the child's health care service will be maintained.

How will this be accomplished by enrolling children in foster care in Medicaid Managed Care (MMC) plans? Who will be making the decisions as to which plan an individual child will be enrolled in? Will the child's biological parent or the foster parent decide? Or will the decision be made by the foster care agency or the local social services district? Given the transitory nature of children in the foster care system, if a child moves from one foster home to another and then another, will the child need to be enrolled in a new MMC plan every time a child moves? For children in institutional settings, will they automatically be enrolled in MMC plans located in the communities where the institutions are located and then reenrolled in different plans when they are discharged from the institution? Who will be responsible for coordinating the services a child is receiving and how will continuity of services be maintained despite the probability of frequent moves within the foster care system for each and every child?

Many of these access issues could be overcome if children in foster care were issued fee-for-service Medicaid cards when they enter care. Under the fee-for-service program, each time a service is received the Medicaid provider must bill the Medicaid program or they do not receive payment. Billing fee-for-service would allow the State to track the services provided and to ensure that children entering foster care are properly screened for medical and mental health needs and that they receive ongoing preventive and necessary treatment. Issuing fee-for-service Medicaid cards to children who do not have them upon entering foster care will increase the likelihood of continuity of care if placements change and also improve continuity of care upon discharge since children will be able to continue to see the same fee-for-service providers in the community.

Children in foster care's needs often differ from the general population. The professionals working with these children must have the ability to identify health related issues and provide proper referrals so these young people may receive the proper and

³ New York State Office of Children and Family Services website
<http://www.ocfs.state.ny.us/main/childhealthcare.asp>

⁴ Fostering Connections to Success and Increasing Adoptions Act of 2008, H. R. 6893, 110th Cong. §205 (2008).

necessary treatment.⁵ The proposal to simply eliminate the exemption which currently prohibits enrolling children in foster care in MMC plans may appear to be a sensible way to cut the enormous cost of Medicaid in New York State, but without ensuring the provision of appropriate and continuous medical and mental health services to this vulnerable population, New York State's children in foster care will be ill-served.

Conclusion

We are extremely grateful to the members of the Assembly and Senate for your leadership and ongoing commitment to expand access to health insurance coverage and access to health care services. As the economic crisis worsens, we look forward to working with you to ensure that New Yorkers are able to obtain medical services. Please feel free to contact Lisa Sbrana at 212-577-3394 or lbsbrana@legal-aid.org or Tamara Steckler at 212-577-3502 or tasteckler@legal-aid.org should you have any questions.

⁵ SUSAN ORR & DENNIS G. SMITH, DEPARTMENT OF HEALTH & HUMAN SERVICES, CHILDREN'S USE OF HEALTH CARE SERVICES WHILE IN FOSTER CARE: COMMON THEMES (2005), note 47 at 6. <http://oig.hhs.gov/oei/reports/oei-07-00-00645.pdf>