American Cancer Society ☙ Children's Defense Fund/New York ☙ Community Service Society of New York ☙
Make The Road New York ☙Metro New York Health Care for All Campaign
New Yorkers for Accessible Health Coverage ☙ New York Immigration Coalition
Public Policy and Education Fund of New York/Citizen Action of New York ☙ Raising Women's Voices ☙
Schuyler Center for Analysis and Advocacy

Testimony on the 2011-2012 New York State Executive Budget

Prepared by:

Health Care For All New York

Health Care For All New York (HCFANY) would like to thank the chairs and members of the respective committees for the opportunity to submit our testimony on the 2011-2012 New York State Executive budget. HCFANY is a statewide coalition of over 100 organizations committed to winning quality, affordable health coverage for all New Yorkers. We strive to bring consumer voices to the policy conversation, ensuring that real consumer concerns are reflected. We also provide expert policy analysis, advocacy, and education on important health reform issues and policies that affect New Yorkers around the state. For more information on HCFANY, visit us on the web at www.hcfany.org.

This memo outlines HCFANY's position on several provisions within the Executive Budget with a large focus on the proposals submitted by the Medicaid Redesign Team (MRT) and included in the Governor's 30-day amendments. Our intention is to support proposals that we believe will best meet the State's goal of lowering costs and improving quality in health care, with the ultimate goal of promoting quality health care for all New Yorkers. We oppose any proposals which we find to be contradictory to these goals.

At the same time, federal health reform is moving forward full steam ahead and nationwide changes are not occurring within a vacuum. New federal requirements outlined in the Affordable Care Act (ACA) touch upon most aspects of our health system, and it is essential that policymakers

remain cognizant of these when reforming our state programs to ensure that New York is adequately positioned for a smooth transition to 2014.

Lastly, we urge the Legislature to remember the vulnerable members of our society who will be most affected by proposed changes. While many cuts to Medicaid may cut numbers from our state deficit, unless they are carefully crafted they may also cut off valuable health services to those who need it most.

Medicaid Redesign Proposals

Before delving into the package of proposals approved by the MRT, we would like to take a brief moment to comment on the redesign process itself. HCFANY applauds the efforts put in by Commissioner Shah and the Department of Health to publicize the meetings, presentations, and hearing proceedings. We believe that the use of streaming media and web-forms likely encouraged greater participation from the public.

However, we were disappointed to find that only one consumer advocate was offered a seat on the MRT. We urge the administration to include a more diverse group of stakeholders in future health proceedings. Further we urge the administration to ensure such proceedings are afforded adequate time to offer and receive comments from the public and to afford adequate time for deliberations before voting on any final proposals.

With respect to the substantive provisions of the package of reforms passed, we are pleased to see that several proposals supported by HCFANY were included in the package of reforms passed. We oppose several other proposals that would seriously undermine the access of many low-income New Yorkers to affordable, quality health care services.

HCFANY Opposes #15 – Comprehensive Fee-for-Service Pharmacy Reform

This proposal includes limiting opioid prescriptions – which play a significant role in pain management – to four prescriptions every thirty days for Medicaid beneficiaries. It would also eliminate the Medicaid wrap for Medicare Part D, thus removing the State's safety-net coverage for people with serious, chronic diseases. HCFANY opposes these measures as they will unwisely reduce or eliminate benefits that assist individuals to remain in optimal health and thereby to avoid developing more acute and costly conditions that will, in the long run, increase Medicaid expenditures.

HCFANY Opposes #17 – Reduce Fee-for-Service Dental Payment on Select Procedures

This proposal will reduce Medicaid payments to dental care providers outside of managed care. HCFANY opposes this proposal as it will potentially lower access to fee-for-service dental services for Medicaid enrollees. Untreated dental conditions in turn can exacerbate other chronic or disabling health conditions, posing a threat to the quality of life for fee-for-service enrollees and increasing program spending in the long run.

HCFANY Opposes #18 – Eliminate Spousal Refusal

Rather than eliminate the spousal refusal provision outright, HCFANY would instead prefer that this provision be targeted to low-income families. For example, the program could meet the dual objectives of securing budgetary savings and yet still offer desperately needed care to low-income families by restricting it to spouses whose income and assets fall within the spousal impoverishment limits for nursing home care ($2,739 income allowance and $74,820 in resources or half of the joint resources up to $109,560, using the same rules that apply in that setting). The same standard should apply for any cases of parental refusal.

These individuals would be fully eligible for Medicaid without a spousal contribution if admitted into a nursing home, so there would be no real cost to continuation of a spousal refusal provision for them. Further, letting the refusing spouse keep the savings up to the impoverishment levels will reduce the likelihood that they will need Medicaid in the future.

This change would respond to CMS' concerns by making spousal refusal unavailable to people whose spouses have substantial assets and income, and would remove the burden from counties having to take legal action against individuals with substantial means. New York City and several other counties already use this standard informally when determining which cases to pursue legally.

A hardship exception should continue to apply for cases where the spouse truly refuses to contribute or document his or her assets. This would protect infirm spouses in potential domestic violence and abuse or neglect situations where, though a couple may live together, only one controls money and finances. For this exception, a statement would be required substantiating efforts to secure the information or support, or facts showing fear of abuse or retaliation. This would be submitted either by the individual applying for Medicaid, or by someone acting on his or her behalf.

HCFANY Opposes #30 – Align Payment for Prescription Footwear with Medical Necessity

This proposal would place new restrictions in Medicaid coverage for certain orthotics. We oppose this proposal as it will significantly reduce access to quality orthotics for low-income

beneficiaries who may not be able to afford to purchase necessary footwear in retail stores. Appropriately fitted shoes are an important factor in maintaining ambulation and foot health and can prevent further costly complications.

HCFANY Opposes Proposal #34 – Establish Utilization Limits for PT, OT, and Speech Therapy/Pathology

This proposal will create utilization limits be set to a maximum of 20 visits in a 12 month period for physical therapy, occupational therapy, and speech-language pathology for enrollees over 21. New York's Medicaid program presently covers these rehabilitation services with no utilization limits. We believe that setting arbitrary limits on these essential services will prevent many enrollees with injuries or disabilities from receiving the adequate treatments necessary to the improvement of their health and well-being, and will result in greater expenditures over time.

HCFANY Supports Proposal #41 – Establish the Public Health Services Corps

This proposal would provide funded positions for health professionals in exchange for a two-year commitment in underserved communities such as rural health clinics, public health department clinics, community health centers, hospital affiliated primary care practices, managed care networks and prisons. This would increase access to care by making a large pool of diverse healthcare professionals available with a commitment to addressing needs in areas that lack essential health care services, and also improve workforce diversity in those areas. HCFANY strongly supports this proposal which will target state funding to workforce development in a manner that reflects the needs of diverse communities.

HCFANY Supports Proposal #55 – Increase Coverage of Tobacco Cessation Counseling

The smoking rate among Medicaid clients is double that of the privately insured, and it is estimated that expanding existing tobacco cessation counseling coverage in Medicaid to include all beneficiaries (not only pregnant women) will result in an return on investment of $2 for every $1 spent within the first 2.5 years alone. HCFANY views this proposal as a public health win because it is designed to save money by keeping people healthy.

HCFANY Opposes #104 – Increase Enrollee Copayment Amounts for Medicaid Fee-for-Service and Family Health Plus; Require Copayments for Child Health Plus

Research shows that higher co-pays make it harder for low-income patients to get access to needed medical care or prescription drugs, which can result in poorer health and a greater need for

higher-cost services and emergency care.[1] A recent statewide survey in New York also found that of people earning less than 200% of the Federal Poverty Level, nearly a third (31%) reported having no savings to fall back on when faced with unexpected costs.[2]

Increasing co-pays for this population is not likely to save enough money to justify putting low-income New Yorkers who are chronically ill and already cash-strapped at greater risk for poorer health outcomes.

HCFANY Opposes #131 – Reform Medical Malpractice and Patient Safety

This proposal would establish a neurologically impaired infant medical indemnity fund and place a cap on the amount that can be awarded in medical, dental, and podiatric malpractice for pain and suffering. HCFANY urges the state to explore other ways to lower medical malpractice premiums than depriving consumers who have been victims of malpractice of the right to be compensated for their non-economic damages.

HCFANY Supports #133 – Administrative Renewal for Aged and Permanently Disabled

Allowing otherwise eligible Medicaid recipients with fixed incomes to renew their health coverage administratively would reduce the burden of annual renewal for individuals who have little or no change in income from year to year. A study by the Community Service Society of New York has documented that our current renewal system has a disparate impact on African American Medicaid beneficiaries, who are significantly less likely to successfully renew than their counterparts of other races and ethnicities.[3] This report recommends adopting administrative renewal and biannual renewal to reduce "churning" in the program for all beneficiaries. Automating this process would also relieve some of the administrative burden on the State by negating the need to process forms annually for this population, which would result in cost savings.

HCFANY Supports #134 – Audit Cost Reports (rather than certification)

This proposal would replace the current requirement that hospitals' Institutional Cost Reports (ICRs) be certified by a certified public accountant prior to submission with a new process under which the Department of Health would contract with independent certified public accounting firms to conduct annual field and desk audits of hospitals' ICRs. The Executive Budget would authorize

[1] Ku, Leighton and V. Wachino, "The Effect of Increased Cost-sharing in Medicaid: A Summary of Research Findings," Center for Budget and Policy Priorities, July 2005. See also, Goodell, S. and K. Swartz, "Cost-Sharing: Effect on Spending and Outcomes," Robert Wood Johnson Foundation, December 2010.

[2] Community Service Society, Statewide Health Reform Poll, November 2007.

[3] Benjamin, E. and A. Garza, "Promoting Equity & Coverage in New York's Public Insurance Programs," Community Service Society, May 2009.

the Commissioner of Health to issue regulations imposing a fee on hospitals to cover the costs of this new system. (Part H § 36). This proposal would also increase transparency and accountability in distribution of Disproportionate Share Hospital (DSH) funding, better positioning New York for continued eligibility for federal DSH funds.

HCFANY Supports #137 – Disregard Retirement Assets Such as 401K Plans for MBI-WPD

Disregarding retirement assets in the Medicaid Buy-in Program for Working People with Disabilities will allow disabled individuals who are working to accumulate modest savings for retirement and retain their eligibility for the Medicaid Buy-in program. This will significantly increase access to the workforce for New Yorkers with disabilities, and will likely increase access to affordable health care within this population by opening up eligibility to a wider demographic.

HCFANY Supports #150 – Develop an Automated Exchange/Medicaid Eligibility System

HCFANY strongly supports this proposal as the most important provision in the redesign package. Moving away from a manual system for determining Medicaid eligibility will best position our state for a smooth transition to the federal health reform changes which will go into effect in 2014. The ACA requires an automated system to be in place by mid-2013, and New York was one of seven states awarded an Early Innovator Grant for federal funding to support state development of this proposal. Under the grant, New York must develop a Medicaid/Exchange system within two years to serve as a model for other states.

New Yorkers need the state to develop a strong, consumer-friendly Exchange that will connect people to quality, affordable health care. Moving from a manual to automated eligibility determination and verification system would jump-start New York in this process and maximize the potential for system efficiency by reducing turnaround time for enrollment, reducing staff hours needed to process forms and make eligibility determinations, and reducing administrative errors.

HCFANY Urges Caution Regarding Proposal # 243 – Accountable Care Organizations (ACOS)

HCFANY has reservations regarding Accountable Care Organizations (243). The promise of ACOs – to improve health status while controlling cost – can only be realized if consumers in ACOs are afforded all the protections of consumers in regulated managed care plans, and if the ACOs only are permitted to bear risk to the extent that they are regulated as insurers of comparable size would be. We believe this proposal needs to be thoughtfully addressed through stand-alone legislation.

HCFANY Supports #990 – Adjust Reimbursement Rates to Support Efforts to Address Health Disparities

HCFANY strongly supports this proposal to explore the establishment of reimbursement rates to support provider efforts to offer culturally competent care and undertake measures to address health disparities based on race, ethnicity, gender, age, disability, sexual orientation, and gender expression. In New York's public insurance programs, African-Americans experience statistically significantly worse health outcomes than other racial and ethnic groups on 10 out of 12 quality measures.[4] However, there are currently no efforts in place to address this disparity within the public insurance system. Similar disparities exist based on other factors, such as gender, age, disability, sexual orientation, and gender expression, though without adequate data collection and reporting it is difficult to tell how each is played out in the realm of New York's public insurance programs.

The State currently rewards plans for improving overall health outcomes as a component of its pay-for-performance Quality Improvement Program, which has resulted in a significant boost in quality benchmark scores for public insurance enrollees. A similar initiative at the provider level which involved reimbursement rates could potentially bring similar results if implemented in a standardized manner for targeted populations.

Likewise, HCFANY fully backs the provision within this proposal to support provider efforts to provide culturally competent care by providing adequate reimbursement for interpretation and translation services to patients with limited English proficiency. Reimbursement for these much-needed services will result in better access to care and increased understanding of conditions and related treatment plans, which could lead to better health outcomes and a reduction in hospitalizations.

HCFANY Supports #1029 – Implement Several Enrollment and Retention Simplification Initiatives

This proposal contains several simplification provisions which HCFANY supports. Namely, pursuing federal approval for two-year renewal periods, developing a short-term method for data transfer between health plans and counties for use while the state transitions to consolidation, allowing for outreach to certain populations based on data matching (such as on tax forms), eliminating the need to present original supporting documents as part of eligibility determination, and allowing administrative renewal for MSP enrollees.

[4] Benjamin, E. and A. Garza, "Promoting Equity and Quality in New York's Public Insurance Programs," Community Service Society, May 2009.

These provisions, when taken in bulk, would remove bureaucratic obstacles to enrollment, reduce disruptions in health care for public insurance enrollees, roughly halve the costs and administrative burden of re-enrolling those who have been involuntarily disenrolled, and better help capture the estimated more than one million uninsured New Yorkers who are eligible for public health insurance programs, but not enrolled. Moreover, these measures will firmly position New York on a sound footing towards the successful implementation of federal health reform.

HCFANY Urges Caution Regarding Proposal #1434 – Convert a portion of Family Planning grants to Medicaid rate reimbursement

The shift of $10 million from the family planning grant to the Medicaid program presents unique opportunities and real challenges. We urge the Department of Health to work in concert with family planning providers to ensure this transition does not inadvertently reduce access to these cost effective, critical health care services.

HCFANY Supports #4648 – Family Planning Benefit Program as a State Plan Service

HCFANY believes that every New Yorker deserves access to quality, affordable health coverage regardless of immigration status. This provision would expand eligibility for the Family Planning Benefit Program to undocumented immigrants, and auto-enroll post-partum pregnant women into the program, thus removing obstacles to reproductive health services for thousands of women in New York.

HCFANY Opposes #4651 – Global Spending Cap on Medicaid Expenditures

This proposal would instate a flat 4% cap on the year-to-year growth of the state's share of Medicaid spending. Should spending exceed this cap, the Commissioner of Health would be authorized to develop a Medicaid savings allocation plan to reduce spending and maintain the prescribed growth rate. HCFANY strongly opposes this proposal on the basis that a failure to maintain spending within this cap would give the Commissioner of Health unprecedented authority to reduce Medicaid spending, unilaterally if necessary. Instead, it is our position that any further changes to the Medicaid program must be attained through an open legislative process.

HCFANY Strongly Opposes #4652 – Reform Personal Care Services Program in NYC

Eliminating Level 1 personal care services and limiting personal care to those not eligible for nursing homes will remove necessary supports from those who need it most, and will speed up deterioration of abilities. In the long run, costs will increase as consumers deprived of personal

services experience deterioration in health status and require more skilled care as a result. Further, this proposal would violate the *Olmstead* decision.

We hope that instead of this drastic and damaging cut, the State will consider alternative routes to lower costs in this area. Enabling more consumers to move out of nursing homes and into the community will reduce costs. Long Term Care Assessment Centers should be given a chance to identify over-authorizations. In addition, the Department of Health is also said to be implementing a Uniform Assessment Tool in the near future, which will simplify the assessment process.

Proposals Removed from the MRT Package

HCFANY Strongly Urges Reconsideration of Proposal #66 – Revise the Indigent Care Pool Distributions to Align with Federal Reform **[Deemed to be "Not Reform"]**

HCFANY strongly supports the transition to an indigent care methodology for voluntary hospitals that is 100% based on losses due to care delivered to uninsured and Medicaid patients, and hopes that this proposal will be reconsidered. Further, we support a methodology which uses uninsured units of services priced at the Medicaid rate as a means of distributing indigent care pool funds. This methodology should allow for a higher coverage ratio for hospitals serving high levels of Medicaid patients.

This proposal will also ensure that New York is in compliance with federal health reform legislation regarding DSH payments. And, while it will no longer allow hospitals to factor bad debts due to unpaid co-pays or deductibles into their funding allocations, it will create a new incentive for hospitals to promote their respective financial assistance programs, and further reduce barriers to access for these programs.

Other Health Budget Proposals

HCFANY Opposes Elimination of the Office of Minority Health (OMH)

The Executive Budget proposes to entirely eliminate dedicated funding for the current OMH and to distribute those resources into a Local Competitive Grant Program, with a dramatically reduced funding pool.

New York State is one of the most racially and ethnically diverse states in the nation. Despite significant overall health spending and extensive public health coverage, New York has not

been able to achieve a high-performing health care system and disparities in health persist. HCFANY believes that eliminating a dedicated office with a formal commitment to the redress of health inequities is clearly a step in the wrong direction. Instead, we urge the Administration to review, reorganize and strengthen this office so that the issue of health equity is infused throughout the programs of the Department in a serious manner to squarely address the significant issue of health disparities in New York State.

Lumping OMH funding into a Local Competitive Grant Program literally and symbolically removes any explicit focus on and attention to the role of social disadvantage in health care access and health status in New York. It risks redistributing funds targeted for vulnerable and socially disadvantaged populations towards programs that are intended to address public health concerns of more advantaged social groups. In addition, the proposed reduction in the State's commitment to health equity runs contrary to the principles laid out in federal health reform.

The ACA has provisions specifically designed to enable, if not require, states to aggressively address issues of health disparities based on race, ethnicity, primary language, gender, and disability status (here in New York, sexual orientation and gender expression would need to be added to these categories). Specifically, it seeks to: (1) improve data collection on health care disparities; (2) assure appropriate language access and cultural competency; (3) expand workforce diversity; (3) increase access to affordable health coverage for low-to moderate income people; and (4)support and expand community health centers and safety net providers. New York can also take advantage of generous federal funding available to states to implement new Health Insurance Exchanges under the ACA and, once they are legislatively authorized, and use part of that funding to address neglected health equity and disparities issues as it designs and implements an Exchange. The Office of Minority Health could and should play a significant role in securing access to funding opportunities and implementation of these important components of the ACA.

To the extent that a Local Competitive Grant Program may be undertaken, it must be a clear and transparent process, and provide the public with easily accessible information.

HCFANY Supports Revisions in How Hospitals Report their Costs and Revenue

HCFANY strongly supports to provision of the Executive Budget which proposes to revise the method by which information is collected from hospitals for the purposes of computing the maximum amount a hospital may receive under the DSH payment process. This would require hospitals to submit a new "disproportionate share hospital data collection tool" to the Department of Health. The data collected with this tool would be used for the purpose of calculating provider-specific disproportionate share hospital caps, in accordance with federal regulations.

Federal regulations require that DSH payments be based on Medicaid and uninsured losses, defined as costs incurred in providing care to Medicaid patients and the uninsured, less payments received for those patients. New York's current DSH methodology is remarkably opaque, unaccountable, and fails to give incentive to hospitals who serve uninsured patients. By adopting use of this new reporting methodology, New York will be better positioned to minimize our risk of losing federal DSH funds due to new requirements set forth in the ACA. Further, this proposal will bring greater transparency and accountability to how these funds are allocated and spent.

HCFANY Supports a Dry Appropriation for the Community Health Advocates Program (CHA)

HCFANY supports continued funding for the CHA program through the $5 million dry appropriation in the Governor's proposed budget as it would allow the State to direct federal funding allocated under the Affordable Care Act to this vital program as soon as it becomes available.

CHA currently operates through a network of 25 community-based organizations (CBOs) around the state to provide assistance to New Yorkers who need to find, enroll into, or troubleshoot aspects of their insurance coverage. Through these CBOs, CHA is able to reach vulnerable and traditionally underserved communities, such as immigrants groups, people with disabilities, homeless people, low-income or low-literacy populations, and the formerly incarcerated. With the capacity to communicate in 15 different languages and locations within diverse communities, CHA is able to provide culturally competent and linguistically appropriate services for consumers in a timely manner. Individuals who seek consumer assistance can also be served through a live-answer central hotline and electronic intake system. Quality assurance is maintained by a regular audit of a centralized database. Consumers are also provided assistance with: navigating enrollment in public and commercial insurance; accessing charity care and local community health centers; accessing new rights under the ACA, including the Bridge Plan and dependent coverage for adult children up to the age of 26, and so forth; and when necessary, filing complaints and appeals when faced with a denial of medical care, negotiating a bill, or other coverage disputes.

This dry appropriation comes at no cost to the State and will ensure that New Yorkers are able to access care and coverage as our state transitions to the full implementation of federal health reform.

HCFANY Opposes Cuts to the Elderly Pharmaceutical Insurance Coverage (EPIC) Program

The current EPIC program wraps around Medicare Part D coverage and is critical to ensuring that seniors do not leave the pharmacy without their prescriptions. The Executive Budget proposes to limit EPIC coverage for drugs only to individuals who hit the Medicare Part D coverage

gap, making low-income seniors pay full premiums ranging from $14.80 to $107.40 per month plus any deductible and co-pays.

HCFANY supports, as an alternative to this cut, the expansion of access to Medicare Savings Programs (MSPs) and consequent automatic enrollment into low income subsidy (LIS) or 'Extra Help', a completely federally funded prescription drug benefit. This would reduce state funded EPIC membership, while preserving drug access for seniors and expanding drug access to people with disabilities under 65 who have Medicare.

From the state's perspective, increasing MSP access makes sense because the cost is much more limited than that of EPIC and the costs that do exist are reduced by at least 50% federal share and in some instances there would be no state expense at all. Consumers would receive increased assistance as well. Not only does the MSP provide automatic enrollment into Extra Help it also provides cost-sharing protection by eliminating annual deductibles, monthly premiums and the donut hole. It limits co-pays to $2.30 for generics and $6.30 for brand name prescriptions – less than most EPIC enrollees currently pay. In addition to the increased cost sharing protection, MSPs pay for Part B premiums so Medicare beneficiaries would have an additional $100 in income each month.

We appreciate this opportunity to share our recommendations. Thank you for your consideration of our concerns.