NEW YORK LEGAL ASSISTANCE GROUP

New York Legal Assistance Group

Testimony to the New York State Legislature

Joint Hearing of the Senate Finance and Assembly Ways and Means Committees

THE 2015-2016 EXECUTIVE BUDGET

TOPIC: HEALTH/MEDICAID

Submitted by

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Founded in 1990, the New York Legal Assistance Group provides high quality, free civil legal services to low-income New Yorkers who cannot afford attorneys. Our comprehensive range of services includes direct representation, case consultation, advocacy, community education, training, financial counseling, and impact litigation. **NYLAG provides hope for thousands of New Yorkers in need each year.** In addition to representing victims of domestic violence, enabling immigrants to achieve citizenship, helping children with special needs to obtain optimal school placements, and preventing foreclosure and eviction, we **provide extensive services to protect and expand access to health care for low-income New Yorkers, including:**

- Assisting older persons, chronically ill individuals, and people with disabilities to access life-saving healthcare and community-based long-term care they need to live dignified, independent lives, and to remain in the community. Increasingly, we advocate for these individuals to obtain vital services from managed care plans, which increasingly control all Medicaid services, even for the most vulnerable populations, under changes enacted in the last few years initiated by the Medicaid Redesign Team.
- Assisting New Yorkers of all ages in navigating the complex bureaucracies to obtain Medicaid, Medicare Savings Programs, EPIC, and related health care subsidies.
- Representing low-income workers in the health care work force, including home health aides, who provide such vital services and struggle to earn adequate wages to support their families.

A. NYLAG BUDGET PRIORITIES ON Medicaid Eligibility and Services:

I. **Preserve Spousal/Parental Refusal (§ 33**) –The Governor's bill would eliminate spousal refusal for many needy spouses as well as children with cancer and other severe conditions whose parents cannot afford the high cost of their care. While many New Yorkers benefit from the new expanded eligibility limits under the Affordable Care Act [ACA], nearly a million low-income New Yorkers are over age 65 or have permanent disabilities. For them, Medicaid remains unchanged by the ACA, with income limits well below the Federal Poverty Level. They are impoverished by the difficult Spend-down program and are subject to low resource limits. Spousal/parental refusal provides a vital protection for vulnerable populations, including abused spouses and children. See details below.

II. **Reject Elimination of Medicaid Personal Care and Other Services for IMMEDIATE NEEDS** Pending the Medicaid Application and Enrollment in a Managed Long Term Care plan (**§§ 36-37)** See details below.

III. **Preserve "Prescriber Prevails."**

B. SUPPORT FUNDING FOR ADVOCACY ASSISTANCE TO HELP VULNERABLE INDIVIDUALS NAVIGATE AND PROTECT THEIR RIGHTS IN THE EXPANDING MANAGED CARE DELIVERY SYSTEM

I. **Support Expansion of Managed Care Ombudsprogram – "ICAN"**

II. **Support Continuing Funding and Restore Prior Funding Levels of the Managed Care Consumer Assistance Program (MCCAP)**

III. **Support Funding for the Community Health Advocates (CHA) program**

C. We support other items in testimony of Medicaid Matters NY.

I. Preserve "Spousal/Parental Refusal" for Vulnerable Populations (Sec. 33)

The Governor's proposed 2015-2016 budget will eliminate the longstanding right of "spousal/parental refusal" for children with severe illness, low-income seniors who need Medicaid to help with Medicare out-of-pocket costs, and other vulnerable populations. As proposed, the "refusal" will only be honored and Medicaid granted if a parent lives apart from his sick child, or a "well" spouse either lives apart from or divorces an ill spouse. NYLAG opposes denying Medicaid to these vulnerable groups, and questions whether this cut will achieve the savings intended. The need for "spousal refusal" is not eliminated by the new availability of "spousal impoverishment" protections to married couples when one spouse is receiving Managed Long Term Care (MLTC) services, a new requirement of the Affordable Care Act (ACA).[1] Moreover, there are a number of populations that would lose vital access to Medicaid after losing spousal/parental refusal protections under the current budget proposal.

A. **Spousal Impoverishment Protections in MLTC Do Not Eliminate the Need for Spousal Refusal**— Beginning in 2014, the ACA requires that all states offer "spousal impoverishment" protections to married persons receiving MLTC or other "waiver" services. This ACA provision at long last *potentially* removes the institutional bias that has long pervaded Medicaid long term care services. Since the 1980's, married spouses of nursing home residents could retain enough income and assets to live without impoverishment, but spouses of home care recipients had to live at the sub-poverty regular Medicaid levels. Now, for a couple with combined income as high as $3,364/month, and combined assets as high as $89,000, one spouse could receive MLTC services without being required to "spend down" most of that income and assets on the cost of medical care, and without needing a "spousal refusal."

   However there are critical gaps in these protections that continue to make spousal refusal essential. First, under New York's policy, the spousal impoverishment protections are only available "post-eligibility." This means that the Medicaid application is first evaluated under regular income and asset rules *without* the generous spousal impoverishment allowances. Under those rules, the application is REJECTED if a couple had $89,000 in assets, even though once the application is accepted and the spouse enrolls in an MLTC plan she would be fully eligible with combined assets in this amount. This creates a Catch-22 barring MLTC enrollment to an eligible applicant, unless the spouse can do a "spousal refusal" for the initial application.

   Similarly, the same couple with combined income of $3,364 would be initially charged with an income "spend-down" of $2,200/month. Spousal refusal is essential to get the application accepted, and to allow the "sick spouse" to enroll in an MLTC plan. Only after MLTC enrollment may the couple request the Medicaid agency to re-budget them with the spousal impoverishment protections – which will allow them to keep their income and assets without any spend-down and without needing spousal refusal from then on.

   New York is implementing this ACA requirement in a way that defeats the purpose of the ACA to remove the institutional bias. An individual who would be eligible with spousal impoverishment protections is

[1] Section 2404 of the Patient Protection and Affordable Care Act (PPACA) amends 42 USC 1396r-5(h)(1)(A) to define "institutionalized spouse" effective Jan. 1, 2014 to include all "medically needy" spouses including those in various home care programs. The State DOH has implemented this through a series of directives – most recently GIS 14 MA/025 - Spousal Impoverishment Budgeting with Post-Eligibility Rules Under the Affordable Care Act (PDF), dated Nov. 3, 2014, rescinds an earlier NYS DOH GIS 14 MA/015, issued August 5, 2014, and reinstates two even earlier directives, Pending further clarification from the federal CMS, "districts are to resume applying the policy provided in GIS 12 MA/013**,** "Spousal Impoverishment Budgeting with Post-Eligibility Rules for Individuals Participating in a Home and Community-Based Waiver Program" and NYS DOH GIS 13 MA/018, "Spousal Impoverishment and Transfer of Assets Rules for Certain Individuals Enrolled in Managed Long Term Care." These are all posted at http://www.health.ny.gov/health_care/medicaid/publications/index.htm.

DENIED Medicaid for MLTC. Only spousal refusal can prevent that perverse result, and make MLTC a true option to institutional care. As proposed, elimination of spousal refusal will again force married persons into nursing homes, in violation of the ACA and the Americans with Disabilities Act.. See Example **A**.

B. **CHILDREN WITH SEVERE ILLNESS**—The refusal law currently applies to any "legally responsible relative" including parents of minor children. There are no "spousal impoverishment- like" protections for children with chronic disabilities. While some are covered by a waivered program, which does not count parents' income, and others benefit from the Medicaid expansion under the ACA, there are still some children with serious illness who will be denied Medicaid without "parental refusal" even if their parents are neglectful or abusive. See Example **B.**

C. **PERSONS RECEIVING HOSPICE CARE AND OTHERS EXCLUDED FROM MLTC** – Terminally ill people enrolled in a home hospice and those who need help with housekeeping chores (personal care Level I) because of their disabilities are excluded from MLTC, and therefore must access Medicaid personal care through their local Medicaid programs. Since they are not in MLTC, they do not get spousal impoverishment protections, making spousal refusal even more critical. Yet the Governor's proposal would deny this protection.

D. **MARRIED ADULTS WHO RELY ON MEDICAID FOR ACUTE AND PRIMARY CARE RATHER THAN LONG TERM CARE**—Married adults who need Medicaid for primary or acute medical care and who are not eligible for MLTC would be denied "spousal refusal" rights under this proposal, even if their spouses are abusive or neglectful. Because of the expanded income limits for adults under 65 under the Affordable Care Act, fewer married persons under age 65 will need to use spousal refusal. However, seniors on Medicare are still subject to the old income limits, which at $1209/month for a couple are *below* the Federal Poverty Line (FPL)($1311/month for a couple). For these seniors, Medicaid can be vital secondary insurance for severe illness, at little cost to the State, since most of their medical care is covered by Medicare. See Example **C.**

E. **MARRIED ADULTS WHO RELY ON MEDICAID TO HELP WITH MEDICARE OUT-OF-POCKET COSTS.** Medicare recipients with incomes under 135% FPL rely on **Medicare Savings Programs** (**MSP**s) to help with Medicare out-of-pocket costs, saving them $104.90 per month in Part B premiums and qualifying them for "Extra Help" (the Part D Low Income Subsidy), which saves dual eligibles an average of $4,000 in prescription costs each year *at no cost to the State*. In fact, for individuals in "QI-1"-- one of the three MSP programs -- the *entire cost* is paid by the federal government, with *no state share*. Spousal refusal can qualify needy seniors and people with disabilities for MSPs. See Examples **D**.

Here are examples of who could be affected by the Governor's proposal:

A. Married Senior Denied Medicaid Home Care –
"Spousal Impoverishment" Rules Can't Protect him Without Spousal Refusal

Mr. M's July 2014 application for Medicaid home care services was denied by NYC HRA, even though the combined Social Security retirement income of him and his wife is $2267, well within the spousal impoverishment limit of $3314 in combined income. Similarly, their assets were well within the allowed asset limits – he had less than the Medicaid limit of $14,500 and her savings totaled $50,000 – under the spousal impoverishment limit of $75,000. With income and assets under the allowed spousal impoverishment limits, they should not have needed "spousal refusal" for him to qualify for Medicaid for Managed Long Term Care (MLTC). However, the ACA's new extension of spousal impoverishment budgeting for MLTC enrollees is only available "post-eligibility" – *after* Medicaid eligibility is determined using the regular income and asset limits, and *after* the case is accepted for MLTC. But for the application, the regular income and asset limits must be used – under which he was not eligible without using spousal refusal. If "spousal refusal" was legislatively eliminated, Mr. M would be denied Medicaid and vital home care services because he is not eligible *without* spousal impoverishment protections – he and his wife have "excess" income and assets under the regular rules.

B. Parental Refusal Provides Crucial Medical Care to fill in Gaps with Employer Coverage or While Applying for Waiver

A Brooklyn mother of a severely autistic 2-year-old was told in February 2015 she had to quit her new job as a teaching paraprofessional in order to qualify her daughter for Medicaid. With parental refusal, she will qualify.

A **7** year old child living in Manhattan has a hearing impairment and requires an assistive device that is not covered by his father's employer insurance. Child Health Plus is not an option because of the father's employer insurance coverage. Mt. Sinai Hospital has assisted the child in obtaining Medicaid with parental refusal since the family cannot afford the cost of the device and their income is over the Medicaid level.

A 13-year-old girl developmentally disabled with microcephaly since birth lost SSI that she had received since she was 8 years old, when her father was promoted at work. Without SSI, she also lost Medicaid including crucial Medicaid home care services such as medical care, speech and physical therapy. With her father's income, she can only qualify for Medicaid with a "parental refusal," until she enrolls in the OPWDD waiver which can take months if not years.

C. Spousal Refusal Gives Lifeline for and Cancer Survivors and Victim of Domestic Abuse to Retain Medicaid

Mrs. S, a Polish immigrant living in Brooklyn, became permanently disabled since having Stage 4 lymphoma. While now doing well in remission, she cannot return to her low-wage work as an office cleaner. Her husband's earnings, while low, would still result in a high spend-down they could not afford. Thanks to spousal refusal, she was able to get Medicaid and pay for chemotherapy, transportation, and crutches. Spousal refusal not only prevented their impoverishment, but ensured continuity of cancer treatment, which is often disrupted because of complicated spend-down procedures.

Ms. D, a 56-year-old Social Security Disability recipient and cancer survivor, could renew her Medicaid coverage through the Medicaid Buy-In for Working People with Disabilities (MBI-WPD) only through spousal refusal. Living in a remote area of a large upstate rural county, she had an abusive spouse she was trying to leave, but had no other place to go. Keeping her MBI-WPD coverage was critical to her well-being and health, and allowed her to retain her Part D Extra Help benefit. Empire Justice Center helped her maintain this lifeline – but only with spousal refusal. Eventually, she did move out on her own, and continues to be in the MBI-WPD program. Spousal refusal probably saved her life at a difficult time.

D. Medicare Savings Program Relieves Burden of Medicare Out-of-Pocket Costs for Disabled Adult and Senior

A woman in Orleans County, age 59, receives Social Security Disability benefits for multiple long-term chronic disabilities. When her husband stopped her coverage under his employer group health insurance when it became unaffordable, sShe didn't know that she needed to sign up for Medicare Part B or Part D right away. Later, she was deterred from enrolling by the high late enrollment penalty. By October 2013, she had stopped taking her prescription drugs or going to doctor appointments because she couldn't afford them. Her monthly Social Security check was only $830. Her husband's earnings (gross $32,000/yr) went toward their mortgage, other living expenses and his health insurance premiums. She was too young for EPIC. Empire Justice Center helped her enroll in the Medicare Savings Program, using spousal refusal. With MSP, she enrolled in both Medicare Part B and Part D without any late enrollment penalty, and automatically receives "Extra Help" with Part D drug costs.

Mrs. D, age 70 and living in the Bronx, suffered vascular and retinal damage from ongoing treatment for cancer. Her Medicare Advantage plan deductible and co-payments were $5,000 per year, including $65 for each specialist visit and $3900/year in co-payments for her seventeen medications. Her Social Security is $780 per month, and her husband's retirement income is $3,000 per month. They have no savings, high credit card debt, and rent and utilities take up a third of their income. Using Spousal Refusal, NYLAG helped her obtain Medicaid and the Medicare Savings Program in June 2013. Medicaid now helps with Medicare coinsurance for her cancer treatment, and the "Extra Help" with Part D – fully paid by the federal government - reduces her prescription co-payments to $136/year. She also saves $104.90 month with help of the Medicare Savings Program paying her Part B premium.

II. Reject Proposed Elimination of Temporary Medicaid to Meet Immediate Needs for Medicaid Applicants for Personal Care and Other Services (Sec. 35-36)

Medicaid applications for the aged and people with disabilities technically must be processed in 45 days -- but often take much longer. Even once approved, it can be months more until a frail senior starts receiving Medicaid home care services. This has always been true, making NY Social Services Law Sec. 133 critical for authorizing medical assistance, including home care services, while an application is pending when there is an urgent immediate need. (See example at end of this section). However, the shift to Managed Long Term Care (MLTC) has exacerbated the problem of delays in initiating vital home care services. Now, more than ever, SSL 133 and related 364-i(7) must be preserved to initiate Medicaid personal care services for a frail senior during the many months before a Medicaid application is processed and an MLTC plan actually starts providing home care, where there is an immediate need.

The delays in accessing home care through MLTC plans is an unintended result of the Medicaid Redesign Team (MRT) shift of delivery of long-term care services from the local departments of social services to MLTC plans. Enrollment in these plans can only begin on the first of a month – this alone causes a full month delay to some unlucky individuals whose Medicaid application is approved, say, on the 2nd of the month. But worse, enrollment must be entered into the computer system by the 18th of the *prior* month. And that data entry cannot be done until the individual, though already found eligible for Medicaid, has been determined eligible for long-term care by a new Conflict Free Eligibility and Enrollment assessment, which takes another week or two to schedule. Thus someone found eligible for Medicaid 45 days after she applied may easily wait another 60 - 90 days until she is enrolled in an MLTC plan and home care services begin. And too often it takes even longer, with longer delays caused by complications resulting from yet other unintended consequences of the shift to MLTC, involve many complex computer systems and procedures.

The Governor would re-define the decades-old provision of New York State Social Services Law section 133 and 364-i(7) so as to carve out Medicaid services from the type of "public assistance" services that must be authorized while a Medicaid application is pending and where there is an immediate urgent need for assistance**.** In the context of the new delays imposed by the MLTC system, the Governor's proposal to deny any immediate assistance to frail seniors and people with disabilities who are seeking Medicaid home care services to meet their most basic needs is cruel, bad public policy and violates the State Constitution and the Americans with Disabilities Act (ADA) as interpreted in *Olmstead*. Personal care services provide help getting out of bed, walking, going to the bathroom, or preparing meals for people who cannot perform these tasks because of severe disabilities. Lack of these services will certainly result force people into nursing homes in violation of *Olmstead*, as shown in the example below.

The State has refused to implement this longstanding law and authorize Medicaid personal care services based on immediate need pending the Medicaid application. A lawsuit called *Konstantinov,* pending for seven years, has resulted in a series of three court orders issued through 2014 requiring the State and New York City Medicaid program to comply.[2] The State now has an appeal pending before the New York State Court of Appeals. Under pressure to comply with the Court orders, in June 2014 the State proposed regulations to

[2] *Konstantinov v. Daines*, 101 A.D.3d 520 (1st Dept. 2012) ,*affirming* 2010 WL 7746303 (N.Y. Sup. 2010, Hon. Joan Madden), *motion to vacate denied*, *Konstantinov v. Daines*, 2014 N.Y. Misc. LEXIS 1137; 2014 NY Slip Op 30657(U)(2014).

implement section 133, which are not yet final.[3] The Governor apparently intends for the proposed statutory amendment to render the lawsuit moot. However, the lower courts found that the requirement to provide Medicaid services to applicants based on immediate need is based not only on state law but also on the Aid to the Needy clause in Article XVII of the New York State Constitution. Even if State reimbursement is not available, sec. 364-i(7), the local districts must provide services to meet these immediate needs under the NYS Constitution. Id. At; *see also Jones v. Berman*, 37 N.Y.2nd 42 (1975). Therefore the statutory amendment will not relieve the State and local districts of their obligations to provide Medicaid services to those who need them.

CASE EXAMPLE – IMMEDIATE NEED PERSONAL CARE SERVICES KEEPS 98-YEAR OLD AT HOME

Though the State Dept. of Health and NYC Medicaid program have refused to implement SSL 133 and authorize Medicaid personal care services, they have authorized care in a handful of individual cases under pressure by the *Konstantinov* lawsuit. One example is Ida, age 98, who lives in public housing in the Yorkville section of Manhattan. Having no family, her sole support is a friend who first met her 30 years ago as her social worker. Frail and prone to falling, Ida was quickly depleting her savings paying privately for 24-hour home care. Her friend asked NYLAG for help in April 2014, when her remaining savings were down to about $60,000. If she waited to apply for Medicaid after she had already spent her savings down to the Medicaid limit of $14,500, Ida would likely have ended up in a nursing home. Though she has some dementia, Ida had capacity sufficient to make clear she desired to remain in her own home. She would have had no savings left to pay for private care during the months it would take for Medicaid to process her application and then for her to enroll in a Managed Long Term Care (MLTC) plan. NYLAG advocated for the NYC Medicaid program to expedite her Medicaid application so that the approval would coincide with the point her savings ran out. But it would still take at least two more months to enroll her in MLTC. Invoking the *Konstantinov* court order, NYLAG and counsel for *Konstantinov* plaintiffs convinced HRA to authorize temporary personal care services outside of an MLTC plan until the MLTC plan enrolled her and actually started providing services. Without these temporary services, Ida would have been forced into a nursing home – having no money left to pay for private care.

III. Reject elimination of "Prescriber Prevails" in Fee-For-Service Medicaid. (Section 6)

The Executive Budget again proposes to eliminate the use of "prescriber prevails" in fee-for-service (FFS) Medicaid for drugs not on the preferred drug list. This provision guarantees that the prescriber of a prescription drug has ultimate professional discretion to determine the medical necessity of a medication for the patient. Although the FFS population is shrinking as more populations are transitioned into mandatory managed care, it is essential that the rights of FFS beneficiaries are protected to the same extent as those in managed care. In addition, FFS beneficiaries include those who may have temporarily lost coverage and cannot immediately be re-enrolled in their plans when their Medicaid is reinstated. The elimination of prescriber prevails for this population could result in disruptions in care. The state has made a commitment to provide "prescriber prevails" in Medicaid Managed Care by including it in the model contract to be used with managed care organizations.[4] The same commitment should remain in fee-for-service Medicaid. The proposed restriction

[3] The proposed regulations were published in the July 16, 2014 State Register at p.20. http://docs.dos.ny.gov/info/register/2014/july16/pdf/rulemaking.pdf. NYLAG and other organizations representing Medicaid recipients have filed comments on the proposed regulations, some of which are posted in article posted at http://www.wnylc.com/health/entry/203/. To date, the State still has not published final regulations – presumably hoping to delay this until April 1, 2015, when the budget is enacted and SSL 133 amended.

[4] The Medicaid Managed Care Model Contract allows for prescriber prevails for the atypical antipsychotic, anti-depressant, anti-retroviral, anti-rejection, seizure, epilepsy, endocrine, hematologic and immunologic therapeutic classes, recognizing

would have a detrimental impact on people with disabilities, including serious psychiatric disabilities, as well as on those who rely on specific drugs and drug combinations. For these individuals, medical providers are best suited to determine which drug would treat their patients most effectively.

B. SUPPORT FUNDING FOR ADVOCACY ASSISTANCE TO HELP VULNERABLE INDIVIDUALS NAVIGATE AND PROTECT THEIR RIGHTS IN THE EXPANDING MANAGED CARE DELIVERY SYSTEM

I. Support Expansion of Managed Care Ombudsprogram – "ICAN"

This past year, the state established the **Independent Consumer Advocacy Network (ICAN)** for people receiving long-term services in mainstream managed care, Managed Long Term Care and the Fully Integrated Duals Advantage (FIDA) program. NYLAG is pleased to see that the Governor's budget provides an additional $5 million of funding to support Ombudsperson services, like ICAN. In addition, we support the Administration's proposal to expand funding of a robust consumer Ombudsprogram that would serve all managed care enrollees over three years. As hundreds of thousands of people will transition to managed care in 2015, ICAN should be available to provide assistance to more people. In order to adequately expand ICAN, NYLAG urges the Legislature to frontload some of the funding intended for expansion of the program in out-years to provide for an expansion of the program this year. The state will be implementing Health and Recovery Plans (HARPs) and initiating behavioral health services through managed care in 2015, which calls for the transition of 700,000 Medicaid consumers with behavioral health needs into integrated health plans, including over 100,000 individuals with serious mental illness and co-occurring substance abuse disorders. The needs of this population are complex, and accessing appropriate services and supports while navigating a new type of care management can be overwhelming, making the services provided by the ICAN more important than ever.

II. Support Continuing Funding and Restore Past Funding Levels of the Managed Care Consumer Assistance Program (MCCAP)

NYLAG is grateful to Governor Cuomo for preserving the Managed Care Consumer Assistance Program (MCCAP) in the Executive Budget. NYLAG is one of five non-profit organizations that make up the MCCAP program, which provide counseling and representation to Medicare beneficiaries throughout New York State on myriad coverage and benefits issues. Additionally, the MCCAP network supports the county Health Insurance Information, Counseling, and Assistance Programs (HIICAPs) throughout the state, taking referrals of complex cases and providing backup during times of high call volume such as the annual Open Enrollment period. Extensive changes to the entire health insurance landscape have made the MCCAP program particularly crucial. Our agencies are able to guide consumers through the navigation of complex issues such as the interplay of Medicare and Qualified Health Plans, and the impact of changes to New York's Medicaid program on dually eligible consumers. We appreciate the continuation of the MCCAP program at the current $1.767 million level. However, a restoration of funding to the 2008-09 level of $1.962 million would allow NYLAG and the other MCCAP organizations to increase our outreach capacity and provide advice and representation to an even larger number of vulnerable elderly and disabled New Yorkers.

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that these classes of drugs treat complex and life-threatening conditions for which precise and appropriate treatment is necessary.

III. Support Funding for Community Health Advocates (CHA)

The Community Health Advocates (CHA) program provides post-enrollment assistance to New Yorkers in insurance coverage of any kind. It is particularly important to low-income people in Medicaid and those in subsidized insurance coverage. MMNY supports funding in the Governor's budget for the CHA program and urges the Legislature to increase it to $5 million so the program can serve more people. Additional funding would also allow contractors in the program to do community outreach and public education.