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 2016-2017 EXECUTIVE BUDGET

TOPIC: HEALTH/MEDICAID

Submitted by

Valerie Bogart, Esq.
Director, Evelyn Frank Legal Resources Program
New York Legal Assistance Group
7 Hanover Square, 18th floor
New York, NY 10004
Direct Dial 212.613.5047
vbogart@nylag.org

January 28, 2016

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 legal services to thousands of New Yorkers in need each year in myriad areas from housing and family law to immigration. We provide extensive services to protect and expand access to health care for low-income New Yorkers, and are active in the Coalition to Protect the Rights of New York's Dual Eligibles, Medicaid Matters NY, and the Medicare Savings Program. People reach us at over 27 hospital and clinic sites of our LegalHealth division or through our intake hotlines. Our direct health access services include**:**

- 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, our clients must 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.

Through our testimony today, NYLAG urges the Legislature to:

I. Preserve Impoverishment Protections for Married Couples and Children with Chronic Illness:
   A. Preserve or expand Spousal Impoverishment resource protections where one spouse is in a Managed Long Term Care plan, waiver program, or a nursing home.
   B. Preserve Spousal/Parental Refusal

II. Preserve "Prescriber Prevails."

III. Expand the Essential Plan for all PRUCOL Immigrants

IV. Ensure that Changes in MLTC Eligibility Requirements Do Not Create Additional Barriers to Care – and Strengthen Oversight and Protections to Ensure Access to Care
   A. Ensure Adequate Local Resources If Home Care Administration Shifts from MLTC Plans back to Local Districts
   B. A High Needs Community Rate Cell, Increased Oversight, Fair Wage Guarantees, and Other Protections Needed to Counter Dis-Incentives for MLTC Plans to Provide Sufficient Services to High-Need Members

V. Preserve Medicaid and "QMB" Reimbursement Rates to Medicare Advantage Plan Providers

V. Remove Medicaid Physical, Occupational & Speech Therapy Visit Caps

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

I. Preserve Protections that Prevent Impoverishment of Married Couples and Ensure Access to Health and Long Term Care for Vulnerable Spouses and Children (Part B, sections 3-4)

The Governor's proposed 2016-2017 budget would make two changes that will impoverish married couples where one spouse needs Medicaid, and deny Medicaid for children with severe illness. First, the Governor again proposes to limit "spousal and parental refusal" to situations where the parent lives apart from his sick child, or where a "well" spouse lives apart from or divorces an ill spouse. Second, the Governor proposes to reduce, for the first time ever, the spousal impoverishment "resource allowance" allowed when the other spouse needs Medicaid for nursing home care, Managed Long Term Care, or other community based "waiver" programs These cuts will cause impoverishment, lead to premature institutionalization and denial of critical Medicaid services for acute as well as long term care.

RECOMMENDATION 1: Preserve or Expand – Rather than Reduce – the Spousal Impoverishment Resource Allowance

Congress enacted the federal "spousal impoverishment" protections in 1988 to prevent one spouse from becoming impoverished when the other spouse needs Medicaid to pay for nursing home care. The Affordable Care Act [ACA] expanded those protections to protect couples where one spouse is enrolled in a Managed Long Term Care plan.[1] This ACA provision at long last *potentially* removes the institutional bias that has long pervaded Medicaid long term care services – removing the financial incentive to institutionalize a spouse. The spousal protections provide a "well spouse" with some financial security, and can prevent her from needing to rely on Medicaid for her own medical or long term care.

States have an option of setting the resource allowance between a minimum floor of $23,844 and a ceiling of $119,220 of the couple's combined assets. The ceiling was originally $60,000 when the federal law was enacted in 1988, and has gradually increased by a statutory consumer price index adjustment to the current $119,220.[2] New York elected the highest federally allowed resource allowance twenty years ago in 1995, when it was at $74,820 with the consumer price index adjustment. However, New York n*ever increased* it by the federal cost-of-living index, while in the last 20 years, the federal maximum resource allowance has increased to $119,220.

---

[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.

[2] 42 U.S.C. § 1396r-5(f)(2)and 1396r-5(g).

The formula under federal law provides that a spouse can keep the **greater** of:

1. the resource allowance as set by the state between $23,844 and $119,220 – New York's allowance has been $74,820 since 1995- OR
2. one-half of the couple's combined assets, up to $119,220.

States like Massachusetts and California set the resource allowance at the highest level permitted - $119,220.[3] There, the spouse may always keep up to $119,220 of the couple's combined resources.

The Governor's proposal will hurt couples with the least assets – between $23,500 and $150,000, while not affecting those with combined assets over $150,000. Here are examples of the disparate impact of the Governor's proposal on couples of more modest means:

- George and Martha have $47,000 in life savings. Before, Martha could keep **all** of these savings when George enrolls in an MLTC plan or enters a nursing home. Under the Governor's proposal, Martha could keep only **half** of their savings, or $23,500.
- Brad and Angelina have $238,000 in life savings. Before, Angelina could keep half of their combined savings -- $119,220 – when Brad enrolls in an MLTC plan or enters a nursing home. This will not change under Governor's proposal. She can still keep $119,220.
- Other examples:

Couple's combined assets	Amount of Assets Community Spouse May Keep		
	If allowance raised to federal maximum	Under Current NY Law	Under Gov's PROPOSED CHANGE
$30,000	$30,000	$30,000	$23,500
$47,000	$47,000	$47,000	$23,500
$75,000	$75,000	$75,000	$37,500
$119,220	$119,220	$75,000	$59,610
$150,000	$119,220	$75,000	$75,000
$238,000	$119,220	$119,000	$119,000
$350,000	$119,220	$119,220	$119,220

New York is well known to have one of the highest costs of living in the nation,[4] which is why the legislature 20 years ago opted for the highest resource allowance permitted by federal law.

[3] 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). About 25 states used the federal minimum allowance.

[4] Mercer LLC rated New York City as having the highest cost of living of all U.S. cities in 2015, followed by Los Angeles and San Francisco. Mercer LLC, 2015 Cost of Living Rankings (June 2015), available at https://info.mercer.com/Cost-of-Living-Ranking-2015.html (last accessed Jan. 27, 2016 with free registration)

Unfortunately, unlike states like Massachusetts, the state legislature did not enact a requirement to increase the allowance by the federal consumer price index, even though the costs of living have skyrocketed. If anything, New York should join Massachusetts,[5] California, and, as of 2010, sixteen other states to opt for the *highest* permitted allowance of $119,220, rather than reducing the allowance to only $23, 500. The inevitable result will be spouses unable to meet their high living costs facing potential eviction or homelessness, and spouses forced to resort to Medicaid because of depleted savings.

Recommendation 2: Reject the proposed elimination of the spousal and parental refusal option for low income Medicaid applicants and recipients.

The Governor's proposed 2016-2017 budget will deny Medicaid to children with severe illness, or to low-income married seniors who need Medicaid to help with Medicare out-of-pocket costs or long-term care. Medicaid would be available ONLY if the parent lives apart from his sick child, or the "well" spouse lives apart from or divorces her ill spouse. NYLAG opposes the requirement that families split up in order to obtain Medicaid to these vulnerable groups. We question whether this cut will achieve the savings intended.

Since 2014, fewer married couples need to use spousal refusal where one spouse enrolls in a Managed Long Term Care (MLTC) plan in order to receive home care. This is because in 2014, "spousal impoverishment" protections first became available to married couples when one spouse is receiving MLTC services, as a result of the Affordable Care Act (ACA).[6] The extension of "spousal impoverishment" protections to married persons receiving MLTC or other "waiver" services is an important tool to prevent unnecessary institutionalization and poverty. It eliminates the longstanding bias that allowed married spouses of nursing home residents to retain enough income and assets to live without impoverishment, but required spouses of home care recipients to live at the sub-poverty regular Medicaid levels.

However, there are critical gaps in these protections that continue to make spousal refusal essential.

First, New York State, in violation of federal guidance,[7] refuses to authorize the spousal impoverishment protections at the time the Medicaid application is filed and approved. Eligibility is first evaluated under regular

---

[5] Massachusetts Medicaid law, Chapter 118E, Section 21A (a)(1)(v), requires that MassHealth "establish the maximum community spouse resource allowance permissible under 42 U.S.C. Sec. 1396r5(f)(2)." In 2016 that amount set by CMS is $119,220.

[6] 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.

[7] CMS State Medicaid Director Letter No. 15-001, May 7, 2015, available at http://www.medicaid.gov/federal-policy-guidance/downloads/SMD050715.pdf (last accessed Jan. 28, 2016).

income and asset rules *without* the spousal impoverishment allowances, so that the application is REJECTED if a couple had $75,000 in assets (or $23,500 if Governor's proposal is enacted). The spouse MUST use Spousal Refusal in order to get Medicaid approved and enroll in MLTC. Only after the application is accepted and the spouse enrolls in an MLTC plan can they request a "re-budgeting" using the spousal impoverishment protections.[8] Then, many couples become fully eligible without Spousal refusal. The State's insistence that spousal protections are available only "post-eligibility" is a barrier to MLTC enrollment, unless the spouse can do a "spousal refusal" for the initial application.

Similarly, without spousal impoverishment income protections, the same couple must use spousal refusal in order for the spouse to have Medicaid approved. Otherwise, a 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 re-budgeting 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.

Here is who is hurt by the Governor's proposal.

I. COUPLES TRYING TO AVOID NURSING HOME PLACEMENT FOR A SPOUSE WITH LONG-TERM CARE NEEDS.

The Governor proposes to eliminate spousal refusal to qualify for Medicaid in the community – but federal law guarantees the right of spousal refusal for nursing home care. So the Governor's proposal will force spouses to place their beloved spouse in a nursing home. This would defeat the whole purpose of the spousal impoverishment protections that are meant to end, rather than perpetuate, the institutional bias in Medicaid. 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.

- **Marie Z was only age 58 when she started showing signs of early Alzheimer's disease.** Her husband of nearly 40 years works full time. They had good health insurance through his employer – which costs the couple $1800/month, but it does not cover long term care. One of their daughters quit her job to care for her, but with Marie's round-the-clock needs they needed formal 24-hour home care. NYLAG assisted her in filing a Medicaid application in March 2015, with her husband filing a Spousal Refusal. It took over seven months until Medicaid was approved in August 2015, in part because Mrs. Z was so young – under age 65 -- that she could only qualify by being determined officially "disabled," which takes extra time. Finally, in October 2015, Marie enrolled in an MLTC plan. Without spousal refusal, she would have had to be placed in a nursing home – removed from her husband of 40 years and her Bronx home.

II. 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

[8] NYS DOH **GIS 12 MA/013,** "Spousal Impoverishment Budgeting with Post-Eligibility Rules for Individuals Participating in a Home and Community-Based Waiver Program," April 6, 2012, available at http://www.health.ny.gov/health_care/medicaid/publications/docs/gis/12ma013.pdf (last accessed Jan. 28, 2016)(was rescinded but then reinstated by NYS DOH GIS 14 MA/025, dated Nov. 3, 2014), available at http://www.health.ny.gov/health_care/medicaid/publications/pub2014gis.htm (last accessed Jan. 28, 2016).

serious illness who will be denied Medicaid without "parental refusal" even if their parents are neglectful or abusive

- **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.

III. **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.

IV. **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 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 limit, which at $1209/month for a couple is *below* the Federal Poverty Line (FPL)($1311/month for a couple). For these seniors, as well as younger couples, Medicaid can be vital secondary insurance for severe illness. For seniors, there is little cost to the State, since most of their medical care is covered by Medicare.

- **Mrs. H, age 25, was newly diagnosed with cancer in November 2015**. Prior to her diagnosis she worked as a freelancer and was uninsured. Her husband works, with an annual salary of about $50,000, but his employer does not offer health insurance. In November 2015 she was rushed to the emergency room of a private hospital and spent several days in intensive care. She is now receiving outpatient treatment at a NYC public hospital. Because of her husband's income, she was ineligible for Medicaid despite no longer being able to work. They faced tens or even hundreds of thousands of dollars in bills from her recent hospitalization as well as the cost of ongoing care. Private health insurance is unaffordable – especially now that she cannot work. NYLAG helped her apply for Medicaid using spousal refusal, and Medicaid was approved. Without spousal refusal, Mrs. H and her husband would suffer devastating financial consequences from her cancer.

- **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.

V. 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**.

- **Ms. K, a Korean immigrant living in Flushing**, is 76 years old has become permanently disabled since his advanced prostate cancer metastasized. One of his cancer medications costs $8,000 per month, even with Medicare Part D. He is eligible for the Medicare Savings Program if only his own Social Security income of $1369/month is counted, but his wife's Social Security of only $600/month puts him over the income limit. They have no savings. With spousal refusal, he qualifies for the Medicare Savings Program, which automatically qualifies him for Extra Help with Part D. In 2015, his Medicare Savings Program enrollment was mistakenly discontinued by NYC HRA. NYLAG was able to get it reinstated with advocacy. Without using spousal refusal, he could not afford the costly medications. New York pays NONE of the cost of the "Extra Help" subsidy for his prescriptions – it is fully paid by the federal government. New York only pays for a portion of the monthly Part B premium - a minimal cost to the state, but of immense value to Ms. K, since eligibility for the Medicare Savings Program automatically qualifies her for "Extra Help" with Part D.

II. Reject elimination of "Prescriber Prevails" in Medicaid.

NYLAG opposes the proposed elimination of the use of "prescriber prevails" in fee-for-service (FFS) Medicaid and managed care programs – the Governor would keep these crucial protections only for atypical antipsychotics and antidepressants, eliminating them for myriad other classes of prescription drugs. 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. The elimination of prescriber prevails will likely result in disruptions in care and create new barriers to obtaining drugs that have been effective for complex medical conditions. The proposal would break the State's previous commitment to provide "prescriber prevails" in Medicaid Managed Care, as it had been included in the model contract with managed care organizations.[9] The proposed restriction 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

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

providers are best suited to determine which drug would treat their patients most effectively and safely, because of their familiarity with their patients' medical and clinical histories. Providers who treat patients with multiple chronic conditions 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.

III. Expand the Essential Plan for all PRUCOL[10] 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 – with income up to 200% of the Federal Poverty Level, rather than the current 138% - 155%, depending on age and living arrangement. 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. Now they can obtain health insurance at a cost of $20 or less per month.

However, an estimated 5,500 immigrant New Yorkers are excluded from the Essential Plan because of lack of federal funding for this group. These are immigrants who the State has always covered because they are Permanently Residing Under Color of Law (PRUCOL). Now they are left without any viable health coverage options except state-funded Medicaid at an income limit between 138% - 155% FPL depending on age and living arrangement. This group includes those with deferred action for childhood arrivals (DACA) status. If these individuals have income above the Medicaid level of 138% -155% FPL, 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.

[10] 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.

IV. Ensure that Changes in MLTC Eligibility Requirements Do Not Create Additional Barriers to Care – and Strengthen Oversight and Protections to Ensure Access to Care

Recommendations:

(1) 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.
(2) Create a High Needs Community Rate Cell, Increase Oversight, Fair Wage Guarantees, and add other protections sufficient to reverse the existing incentives within the capitation for MCOs or MLTC plans to deny necessary services to enrollees with significant disabilities, or to push them into institutions or out of their plans.

NYLAG 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). We understand that this new requirement is estimated to deny MLTC enrollment to about five percent (5%) of prospective members. With nearly 140,000 people enrolled in MLTC plans statewide, this change will affect thousands of people needing home care services.

(1) Ensure Adequate Local Resources If Home Care Administration Shifts from MLTC Plans back to Local Districts

Among our concerns are how these individuals will access Medicaid home care services. They will still be eligible for Medicaid personal care, consumer-directed personal assistance (CDPAS) or other home care services, which they presumably will need to access at their local Department of Social Services Medicaid program, as they did prior to mandatory MLTC. However, with the roll out of mandatory MLTC statewide now complete, many local districts have severely reduced resources available in their Medicaid home care programs, with insufficient staff to administer the programs and insufficient home care contracts to assign aides.[11] At least one county has noted that it no longer has nurses to assess people for personal care, in part because MLTC plans have hired all of the nurses at better reimbursement rates. 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.

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. Because the already under-resourced local districts would be picking up a higher and more complex homecare caseload

[11] 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.

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.

(2) A High Needs Community Rate Cell, Increased Oversight, Fair Wage Guarantees, and Other Protections Needed to Counter Dis-Incentives for MLTC Plans to Provide Sufficient Services to High-Need Members

We presume that the proposal is intended to save the State money by removing those people with the lowest need from MLTC, since the cost of providing them home care services on a fee for service basis may well be less than the capitation rate the State pays to the MLTC plans. However, the result will be that those left in MLTC will all have higher need. The insurance model depends on each plan being able to spread the risk across all of its members, with its members ranging over a continuum of need and cost. By removing the lowest-need contingent, we fear that consumers with higher needs will be even less likely to get the care they need – as advocates, we have long seen consumers denied the amount of home care services they need by MLTC plans.

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 must be addressed:

- **Governor has not proposed additional funding to pay for increased aide wages who are, since October 2015, finally covered by the Fair Labor Standards Act's overtime and travel requirements**. Low wages are a chief cause of the shortage of personal care aides, particularly upstate. To avoid paying overtime, home care agencies are capping aide hours to avoid the requirements, resulting in further reduction of the available workforce, and disrupting continuity of care by long-time aides familiar with the consumer's complex chronic conditions. The State must allocate sufficient funds to pay for overtime to maintain continuity of care and ensure adequate supply of aides. This includes providing managed care capitation rates that are sufficient to account for increased wage costs and requiring that any increased capitation rate be used to increase the availability of aide services – with enforceable monitoring of compliance.
- **Create a High Needs Community Rate Cell** sufficient to reverse the existing incentives within the capitation for MCOs to deny care, or push enrollees with significant disabilities into institutions or out of their plans. 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. A high needs rate cell available only for care in the community would incentivize the plan to provide adequate services in the home. This becomes even more important if the Governor's proposal succeeds in eliminating the lowest need consumers from the plan's membership.

- **Improve oversight and accountability of managed care plans**. This should include:
    - Requiring plans to report any home care hour reductions, including the previously authorized amount, the reduced amount and the reason for reduction, so that the Department of Health can identify and investigate patterns of reductions.
    - Include transition into Nursing Facility as a reported incident in order to show what the plan did or did not do to keep people in the community, including data on the number of hours of home care previously authorized by the plan, if any, the reason for permanent placement, and an explanation of why services are not being provided to the individual in a community setting. If the member was hospitalized, and then disenrolled from the plan, the plan should remain accountable for the subsequent transition of that member to a Nursing Facility.
    - 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). Fair hearing data should include the number of fair hearing requests that are withdrawn, with no decision rendered. The Department of Health should investigate a sample of those withdrawals to ensure that plan members have not been unduly pressured to withdraw fair hearing requests or to agree to reduced hours without knowing their rights.
    - Tracking number of people who voluntarily or involuntarily disenroll from and enroll in each plan on a monthly basis
    - All of the above data must be publicly reported.

V. 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 Advantage member's 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.

For years, we have received numerous calls regarding dually eligible individuals who are being "balance billed" for services received from a Medicare provider, meaning that the provider bills the individual for the deductible or coinsurance due under Medicare.[12] 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 for beneficiaries who have "Original Medicare" in the same manner that is now proposed for people in Medicare Advantage plans. As a direct result of that change in reimbursement, a chain pharmacy and Medicaid provider has informed a dually eligible consumer that it will have to start charging him the $60-70 co-insurance for his Medicare Part B medications. Once the provider is educated on the prohibition on balance billing, the provider or pharmacy may decide to simply no longer treat the consumer or fill his 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.

---

[12] In an Informational Bulletin issued January 6, 2012, titled "*Billing for Services Provided to Qualified Medicare Beneficiaries (QMBs)*," available at http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-01-06-12.pdf, the federal Medicare agency - CMS - clarified that providers MAY NOT BILL QMB recipients for the Medicare coinsurance. This is true whether or not the provider is registered as a Medicaid provider. This is a change in policy in implementing Section 1902(n)(3)(B) of the Social Security Act , as modified by section 4714 of the Balanced Budget Act of 1997, which prohibits Medicare providers from balance-billing QMBs for Medicare cost-sharing.

VI. 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.[13]

- 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.[14]

[13] 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)
[14] 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)

- 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.[15]

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.[16]

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.[17] 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 services.[18] 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.[19]

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.

---

[15] 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)

[16] 42 U.S.C. § 1396r-5l(g).

[17] 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)

[18] 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

[19] 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)

VII. Support Funding for Community Health Advocates (CHA)

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

Community Health Advocates is a statewide network of 30 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 – both private insurance and Medicaid -- 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.

Once funded at $6million, the loss of federal funding last year put the program at risk. The Governor and New York Legislature stepped in and funded it in 2015-16 at a $4 million dollar annualized level. We appreciate the Governor's continued support for the program, 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.

It should be noted that NYLAG is not one of the 30 organizations funded under the CHA program – so our support for this program brings no financial resources to support our own work. Rather, we rely on this program to refer many consumers who call our own hotlines who need help from CHA in navigating the health care system, which is notoriously challenging. Our own hotline specializes in helping the aged and disabled – not the consumers who apply for Medicaid or qualified health plans on the Exchange. 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. If its funding is not maintained, New Yorkers facing denials or reductions in critical health services will have nowhere to turn for help.

* * *

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

For more information:

Valerie J. Bogart, Director
Evelyn Frank Legal Resources Program
New York Legal Assistance Group
7 Hanover Square, 18th Floor
New York, NY 10004
tel 212.613.5047
fax 212.714.7450
vbogart@nylag.org
http://nyhealthaccess.org