NYLAG
New York Legal Assistance Group

REJECT MRT PROPOSALS THAT WILL REDUCE ACCESSS to MEDICAID LONG TERM CARE & JEOPARDIZE ENHANCED FEDERAL SHARE FROM CORONAVIRUS PACKAGE

NYLAG uses the power of the law to help New Yorkers in need combat social and economic injustice. We address emerging and urgent legal needs with comprehensive, free civil legal services, impact litigation, policy advocacy, and community education. NYLAG serves veterans, immigrants, seniors, the home-bound, people with disabilities, patients with chronic illness or disease, low-wage workers, low-income members of the LGBTQ community, Holocaust survivors, as well as others in need of free legal services.

In light of the current pandemic, the federal government is poised to increase the Federal match for Medicaid by 6.2%. However, the bill likely to be enacted includes a maintenance of effort section which would deny any state the increased support if they impose eligibility standards, methodologies, or procedures more restrictive than what was in effect as of January 1, 2020. New York State could be denied the enhanced FMAP if, as part of the 2020-2021 budget, the State adopts any of the MRT II proposals that would reduce financial eligibility for Medicaid and access to Medicaid home care and prescription drugs. Eliminating spousal refusal, reducing the spousal impoverishment allowance, imposing a lookback on home care, and changing home care criteria to deny care to people with Alzheimer's disease are also bad policy and potentially violate the ADA,

REJECT CUTS IN ACCESS TO HOME CARE

1. REJECT CHANGE IN ELIGIBILITY CRITERIA FOR MEDICAID HOME CARE

- Would require more than two activities of daily living (ADLs) for which consumer needs at least "limited assistance" up to the maximum of total dependence. This proposal is designed to DISQUALIFY people with Alzheimer's disease and other cognitive impairments because it would not count an ADL for which the consumer needs "Supervisory" assistance, which is the prompting and cueing assistance typically needed by people with cognitive impairments. The "more than two ADL" proposal appears to be an attempt to align the Medicaid criteria with the U.S. Tax Code's definition of a qualified long term care insurance policy. See 26 U.S.C. § 7702B. However, the tax code expressly permits coverage for people who require assistance with two out of six ADLs, ***or*** who "**[require] substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment**." 26 U.S.C. § 7702B (c)(2)(A)(iii). The MRT proposal would discriminate against people with cognitive impairments, violating Medicaid law and the ADA, and requiring MORE than two ADLs is stricter than any private long term care policy..
- Would eliminate "Level I" personal care, also known as "Housekeeping," which is already limited to only 8 hours per week for those whose impairments make them unable to do their own laundry, clean, grocery shop, and cook. This service is a critical preventative service – keeping older people independent and accident-free by providing a critical support.

2. **Modify Growth Cap on MLTC Plan Enrollment** – The proposal aims to curb MLTC plan enrollment by incentivizing MLTC plans to keep their enrollment growth under a target percentage. It is true that some plans have had disproportionate growth, and their aggressive marketing activities and arrangements with tprovider home care agencies to refer potential members should be reined in. However, the incentives are misdirected. The plans with disproportional growth are recruiting low-need members, who earn the plan profits because they do not need extensive home care services. A cap on enrollment growth will still allow plans to "cherry pick" and recruit low need members – they will meet their cap by refusing to enroll HIGH-need members, who already now face barriers to enrollment. As an alternative, plans should be banned from marketing and from these referral arrangements. Consumers should be auto-assigned randomly to MLTC plans, so that every plan has its share of high need members.

3. **PRESERVE CDPAP -** The Coronavirus crisis highlights the crucial role played by the Consumer Directed Personal Assistance Program in ensuring a supply of home care workers. With certain family members, neighbors, or fellow church members authorized to serve as personal assistants, they are more likely to be able to continue to work in a public health emergency. Long before this current crisis, there has been a dire shortage of aides, particularly outside of New York City. Without the CDPAP program there simply would be no aide coverage in many areas. Even in New York City, this program enables the consumer to have an aide who speaks their language, who cooks food from their culture, and who, in this crisis, shows up. Proposals to eliminate the requirement that plans and local districts inform consumers of the availability of this service, or to limit the number of Fiscal Intermediaries in a way that will limit access, should be rejected.

REJECT CUTS IN MEDICAID ELIGIBILITY

1. Keep Spousal Refusal. For 27 years, the legislature has rightly rejected a change that would deny Medicaid to a married person or child whose legally responsible relative (spouse or parent of a young child) unless the spouse or parent both fails to provide support *AND* is absent from the household. This would require couples to separate or divorce or to institutionalize the sick spouse, and parents to live apart from sick children. It will impoverish the "well" spouse, who will be unable to meet living expenses and will soon become a public charge on Medicaid as well; the well spouse often delays seeking help for themselves even as they decline. MLTC plan members would still be entitled to use spousal refusal because federal law gives them the same rights as nursing home residents. However, the proposed change would deny Medicaid to:

(**a) People who need home care but are excluded from or awaiting enrollment in MLTC plans** -- those receiving Hospice Care for whom spousal impoverishment protections are not available because these individuals are excluded from MLTC enrollment, as well as those newly applying for Medicaid who are not yet in an MLTC plan, and those whose need for home care is so urgent that they qualify for "Immediate Need" home care but whose needs present such a financial hardship that it would devastate their well spouse;

(b) Seriously Ill Children and Adults with Disabilities who rely on Medicaid for acute and primary care and crucial subsidies for Medicare out of pocket costs which are high; Medicare cost-sharing for people with chronic needs applies each time they seek medical care.

2. Don't Cut Spousal Impoverishment Resource Allowance. The MRT proposes to reduce the spousal impoverishment resource allowance from $74,820 to the lowest allowed by the federal government -- only $25,728. With its high cost of living, New York should use the highest federal option ($128,640) rather than the lowest. The formula under federal law provides that a spouse can keep the *greater* of:

Option 1. Resource allowance as set by the state (between $25,728 and $128,640) or

Option 2. One-half of the couple's combined assets, now up to $128,640.

Eleven states, such as Massachusetts, Georgia, Florida, Louisiana and California, set the resource allowance at the highest level permitted - $128,640 -- and build in a cost of living increase. In those states, Option 1 is always greater -- the spouse may always keep up to $128,640 of the couple's combined resources.

When New York set the resource allowance in Option 1 of this formula in 1995, New York ***elected the highest*** federally allowed resource allowance at the time -- which was then $74,820 – but ***never enacted the federal cost-of-living index***. In the last 25 years, while the federal ceiling has increased to $128,640, New York's allowance has stayed flat at $74,820.

The MRT proposal hurts those with the least resources – with life savings under $74,820 (Couples A – D in table on marked in **red**), while not affecting at all those with higher resources (couples E-G).

Couple	**Spouse's assets**	**Amount Community Spouse May Keep**		
		In CA, MASS etc. (federal maximum)	Under Current NY Law	**Under PROPOSED CHANGE**
A	**$30,000**	$30,000	$30,000	**$25,728**
B	**$47,000**	$47,000	$47,000	**$25,728**
C	**$75,000**	$75,000	$74,820	**$37,500**
D	**$123,600**	$128,640	$74,820	**$61,800**
E	$150,000	$128,640	$75,000	$75,000
F	$257,280	$128,640	$128,640	$128,640
G	$350,000	$128,640	$128,640	$123,640

Impoverishing "well" spouses of nursing home residents or MLTC members will put the "well" spouses at risk of losing their homes, and force them onto Medicaid.

Now, Spousal Impoverishment and Spousal Refusal work together. A "well" spouse with $3000 income and $50,000 in savings executes a "spousal refusal" when the "ill" spouse applies for Medicaid to enroll in MLTC. As soon as the ill spouse is enrolled in the MLTC plan, the "spousal impoverishment" protections take effect, which *totally protect* the well spouse's assets (at the current levels, not if the proposal to reduce the resource allowance passes). Spousal impoverishment may not be used in the initial application, so spousal refusal is necessary. As proposed, the ill spouse will be DENIED Medicaid and may not enroll into MLTC.

3. **REJECT FIVE-YEAR LOOKBACK for ELIGIBILITY for MLTC and OTHER MEDICAID HOME CARE**. When a nursing home resident applies for Medicaid for nursing home care, the local Department of Social Services ("DSS") must review all of the financial records for the applicant and their spouse for the past five years. If any assets were transferred during the five year "lookback" period, Medicaid will not pay for nursing home care for a "penalty period" based on the amount transferred. The larger the transfer, the longer the penalty period. New York has wisely never exercised the federal option of imposing a lookback for community-based long term care. Because a lookback on community-based services would cause huge delays in accessing home care, backups in hospitals, pressure on spouses and caregivers, it would lead to unnecessary institutionalization that violates the *Olmstead* ruling enforcing the Americans with Disabilities Act. New York must not now implement a new lookback requirement for community-based long term care.

The procedures for applying for Medicaid home care are different in critical ways than those for applying for Medicaid for nursing home care. One can only apply for Medicaid for nursing home care if she is already in a nursing home. Reviewing five years of financial records often takes as much as six months to a year. For a nursing home applicant, this delay causes no harm; the applicant is receiving care in the nursing home. In contrast, a lookback for community-based care would have to be conducted BEFORE Medicaid is approved and services start. This would cause harmful delays for seniors and people with disabilities desperately in need of aide services to live safely at home. This delay is particularly unfair for the vast majority who are destitute and *never had any assets to transfer* – the 5-year review takes as long for them as for the few who may have transferred assets. There are already delays in processing Medicaid applications for community-based care *without* a five-year lookback. If a lookback is added to the applications, approvals will take 6 months or more – notwithstanding a 45-day limit mandated by federal regulations. During that time the applicant receives no Medicaid services at all. To impose a lookback only increases the demands on the spouse and children who are unable to provide the care because they are employed, raising children, or not well themselves.

A lookback for community Medicaid will also quickly overload hospitals. The current emergency has hospitals and state officials already looking for additional beds to keep up with the demand as infections exponentially increase. A lookback for community Medicaid will stymie hospital efforts to safely discharge patients who do not need acute care. However, individuals discharged without needed care at home will end up back in the hospital after they fall or other episodes.

Adding a lookback period for home care would add a tremendous administrative burden to an already backlogged DSS. Federal regulations generally require an application to be acted upon within 45 days of filing. As it stands now, DSS routinely takes months and approaching a year to decide an application.

Start Date for a Penalty_New York's MLTC program is under a Section 1115 waiver. A federal policy for triggering the lookback and start of the penalty period does not currently exist - there is no CMS guidance whatsoever on a lookback for such waivered services. This will cause confusion and additional hardship

REJECT CUTS IN PRESCRIPTION & OVER-THE COUNTER DRUG ACCESS

1. Preserve "prescriber prevails" in the Medicaid fee-for-service and managed care programs.

NYLAG opposes the MRT's proposed elimination from the Medicaid fee-for-service and managed care programs of important prescriber prevails protections for prescription medications, which NYS has maintained for therapeutic classes prescribed for particularly complex conditions. In managed care, the MRT would repeal state law that requires managed care plans to approve these medications for complex conditions in specific therapeutic classes when the physician has prescribed them for the patient as medically necessary for years: atypical antipsychotics, antidepressants, anti-retroviral, anti-rejection, seizure, epilepsy, endocrine, hematologic and immunologic. In fee for service Medicaid, the prescriber's professional opinion that a medication not on the preferred drug list is medically necessary would no longer prevail. This repeal would create new barriers to individuals obtaining medications prescribed by their doctors on which they have been stabilized.

Because of their knowledge of their patients' medical and clinical histories, physicians are in the best position to know which medications and combinations of medications are most appropriate and safest for their patients, and should have final say. This is particularly true when it comes to patients with complex needs, chronic illness, and co-occurring disorders. Providers who treat these patients 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. Even if a recipient might prevail in an appeal, the appeal process may disrupt continuity of vital medications, inflicting avoidable harm where a provider has often previously reached the decision to prescribe a treatment after exhausting other options.

2. Maintain coverage of Over-the-Counter (OTC) Drugs and Do Not Increase Copayments

The MRT proposes to reduce coverage of certain OTC products it does not specify and would also increase copayments, "with exceptions for vulnerable populations." With so many drugs that were formerly prescription drugs and are now OTC, these drugs are a crucial part of medical treatment. They must be prescribed by a doctor, ensuring medical necessity. Any attempt to carve out a "vulnerable population" or those with particular diseases who will be exempt from increased copayments may well violate federal "comparability" rules, which prohibit states from limiting services based on disease or diagnosis.

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