



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 2018-2019 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 legal services to thousands of New Yorkers in need each year in myriad areas, including services to protect and expand access to health care for low-income New Yorkers. We assist older persons and people with disabilities to access health care and community-based long-term care they need to live dignified, independent lives, and to remain in the community. We assist New Yorkers of all ages in navigating the complex bureaucracies to obtain Medicaid, Medicare Savings Programs, EPIC, and related health care subsidies. We are active in the Coalition to Protect the Rights of New York's Dual Eligibles, Medicaid Matters NY New York, and the Medicare Savings Coalition. People reach us at over 27 hospital and clinic sites in New York City, through our intake hotlines, and through our website NYHealthAccess.org.

Through our testimony today, NYLAG urges the Legislature to:

1. **OPPOSE Limits on Access to Medicaid Access for Married Individuals and Sick Children by rejecting the Governor's proposals to:**
 - a. **Limit "Spousal Refusal"** so that it would be eliminated for all except those in Managed Long Term Care (MLTC), other Waivers, and Nursing homes, for whom spousal refusal is mandated by federal law. This puts at risk spouses who need home care but are excluded from or not yet enrolled in an MLTC plan, sick children who need care a parent cannot afford, or those who need the crucial Medicare Savings Program or Medicaid for medical treatment or for to access "Extra Help" with costly prescription drugs. (HMH Part B § 6).
 - b. **Weaken "Spousal Impoverishment" protections by limiting the assets that the "well spouse" may keep to only \$24,180, the federal minimum.** This is a 75% reduction from the current limit that NYS state in 1995 and has never increased -- \$74,820. Even the current NYS limit is already far below the federal maximum (\$123,600). This reduction will hurt those with the most modest resources, those under \$75,820, and not affect at all those with higher assets. (HMH Part B § 7).
2. **OPPOSE the following changes to the MLTC program:**
 - a. **Disenrollment from MLTC of individual who have been placed in a nursing home for 6 months. The cost of their nursing home care would be shifted from the MLTC plans to fee-for-service Medicaid,** creating an incentive for MLTC plans to place members with high needs in nursing homes, rather than provide them with high more hours of home care, thereby allowing them to remain in the community. (HMH Part B § 5).
 - b. **Disqualification of MLTC members with an assessment score of 9 or lower.** These individuals have been determined to need personal care services, though in lesser amounts than other members. They will face barriers obtaining personal care from their local Medicaid districts, which lack the resources to administer these services. (HMH Part B § 3).
 - c. **Lock-In -** For the first time since MLTC became mandatory 5 years ago, members would be barred from changing plans after the first 30 or 45 days. (HMH Part B § 4).

- d. **Disenrollment from MLTC if plan provides no homecare services in the first 30 Days of enrollment**
If plans failed to start services in 30 days, members would be disenrolled, rewarding plans for their delay and harming Medicaid recipients. (Administrative proposal).
 - e. **Contracting limits – Caps number of licensed home care services agencies an MLTC plan may contract to 10 agencies.** This cap will increase barriers to consumer access, as many plans already do not have an adequate network of home care provider agencies to provide authorized services. Consumers have rights under federal regulations to adequate networks of providers.
3. **OPPOSE Elimination of important “prescriber prevails” protections for prescription medications.** The proposed repeal would create new barriers to individuals with complex conditions who rely on medications on which they have been stabilized. (Part D, § 4-5).
4. **QUALIFIED SUPPORT** for increasing the cap on Physical Therapy (PT) visits from 20 to 40 visits per year. While NYLAG favors the effort to increase access to medically necessary physical therapy, the proposal falls short of providing the appropriate level of access to physical therapy and does nothing to address the cap on Speech and Occupational Therapy visits. Access to these therapies should not be restricted with a flat cap, and should not be contingent on savings from performance targets in the bill. (HMH Part A, §5).

MORE ABOUT THE BUDGET PROPOSALS

1. REJECT Proposals to Abolish “Spousal Refusal” and Reduce “Spousal Impoverishment” Protections

a. Preserve “Spousal “ and “Parental” Refusal to Ensure Access to Health and Long Term Care for Vulnerable Spouses and Children (Part B, section 6)

RECOMMENDATION: Reject the Governor’s proposal to limit spousal refusal only to married members of MLTC plans or other waivers (who are already entitled to it under federal law). Chronically ill children and low-income seniors also need Medicaid for costly medical treatment, to help with Medicare out-of-pocket costs, or for home care outside of an MLTC plan or waiver. The Medicaid income limit for adults is so low – 17% *BELOW* the Federal Poverty Level – that a spouse’s moderate income or assets can easily disqualify a vulnerable person for health care. While children may have higher limits under the Affordable Care Act, there are those few for whom treatment of severe chronic conditions is so expensive that their parents cannot afford it. Only if the parent or spouse lives *apart* from their loved one could spousal or parental refusal be used. NYLAG opposes the requirement that families split up – or be forced to place a sick spouse in a nursing home -- in order to obtain Medicaid for these vulnerable individuals and avoid impoverishment for a “well” spouse.

While spousal refusal would be available for people in MLTC, since federal law requires it,¹ it is still needed in other circumstances.

1. Catch-22 – Spousal Refusal is Needed Just to Get in the Door to Apply for Medicaid in Order to Enroll in MLTC, where Spousal Impoverishment protections take effect. Though spousal refusal and spousal impoverishment protections are available *after* a person enrolls in MLTC, “spousal refusal” is needed *before* then, when they a person applies for Medicaid. New York State, in violation of federal guidance,² refuses to grant “spousal impoverishment protections” (discussed below) until *after* the Medicaid application has been approved and the applicant is enrolled in an MLTC plan. A two-step process must be used, illustrated with an example on the next page. First, in the Medicaid application, eligibility is determined using the harsh regular income and asset rules *without* the spousal impoverishment allowances, so that the application is REJECTED if a couple had a combined \$90,000 in assets, even though those same assets will be allowed *after* one spouse has enrolled in MLTC under the “spousal impoverishment” protections (though the Gov. proposes to reduce the allowed amount to a combined \$39,000 in assets). The same is true if the spouse’s income exceeds the low regular

¹ The Affordable Care Act expanded the definition of a “community spouse” to include not just spouses of nursing home residents but spouses of people enrolled in “waivers,” such as MLTC plans or the Traumatic Brain Injury waiver program. “Community spouses” are entitled to both “spousal impoverishment” protections and spousal refusal; their income and resources may not be deemed available to a spouse in a nursing home or MLTC plan. This is the same as spousal refusal. See 42 U.S.C. §§ 1396r–5(h)(1)(A); 1396r-5(b)(1)(income); § 1396r-5(c)(4)(resources); Social Services Law §366-c

² 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).

Medicaid limits -- spousal refusal must be used. Once the sick spouse is enrolled in an MLTC plan, in step two, the income and assets are rebudgeted with “spousal impoverishment” protections.³

EXAMPLE: MARY, age 80, needs MLTC. Her husband, BOB, is age 82. Their income and assets are:

		ASSETS	INCOME		
Mary		\$15,000	\$1,500		
Bob		+ \$60,000	+ \$2,000		
Total		\$75,000	\$3,500		
PROPOSED Mary’s Medicaid application with NO spousal refusal	- Medicaid Limit	-22,200	-\$1,253		
	EXCESS RESOURCES or Excess Income	\$53,800	\$2,247	The Medicaid application is DENIED for excess resources. Mary has a high spend-down she cannot meet. She can’t enroll in MLTC. Either they divorce, she goes to a nursing home, or become impoverished.	
CURRENT 2-STEP PROCESS 1. Mary’s Medicaid application	Spousal Refusal Needed to “Get in the Door”	ELIGIBLE	Spend-down is \$658	Medicaid application is APPROVED based solely on Mary’s income and resources. She has a \$658 spend-down which will be reduced to only \$19 once she enrolls in MLTC plan, because of Spousal Impoverishment protections.	
		Her assets alone are within limits (\$15,150).			
2. Mary’s budget once enrolled in MLTC plan	Spousal Impoverishment Protections Kick in	ELIGIBLE without spousal refusal	ELIGIBLE without spousal refusal. \$19 spend-down	ASSETS - BOB can keep all his \$60,000 in savings since it is under the \$74,820 Spousal impoverishment limit. Mary can keep hers. INCOME: BOB can keep \$3,090 of their combined income and Mary can keep \$391. This leaves her with a \$19 spend-down.	

³ NYS DOH [GIS 12 MA/013](http://www.health.ny.gov/health_care/medicaid/publications/docs/gis/12ma013.pdf), "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).

2. The Governor's proposal will hurt many people who are not n MLTC plans and waivers.

I. **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 waived 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:

- **A Brooklyn mother of a severely autistic 2-year-old** was told she had to quit her new job as a teaching paraprofessional in order to qualify her daughter for Medicaid.
- **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.

II. **Persons receiving Hospice Care and others who need home care who are excluded from MLTC**

People who are excluded from enrolling in MLTC or other waivers cannot benefit from spousal impoverishment protections, so depend on spousal refusal even more. They access home care from their local district rather than an MLTC plan. They include:

- Terminally ill people enrolled in a home hospice., and
- Those who need help with housekeeping chores (personal care Level I) but not help with personal activities of daily living (personal care Level II).
- People who may not need 24-hour care, but for whom an aide’s assistance with personal care needs is no less vital to maintain their health and safety at home. If the Governor’s proposal in this budget is successful, those who score under 9 on the Uniform Assessment tool will be excluded from MLTC plans, even though they still need an aide to maintain their health and safety at home. Many have needs severe enough to qualify for nursing home care (requires a minimum UAS score of 5).

III. **Married Adults Who Rely on Medicaid to Help with Medicare Out-of-Pocket Costs.**

Lev is a 67 year old Russian immigrant who lives in Brooklyn. Because he came to the U.S. through a family reunification application, he is not eligible for SSI for the first five years, and has no source of income. His wife, under age 65, and who arrived in the U.S. earlier, supports them by earning \$2100/month gross as a home care aide, which pays all of the family expenses. When Lev developed stomach cancer, the copays and coinsurance through his wife’s employer-based insurance proved unaffordable. Her work insurance did not provide medical transportation he needed due to the severity of his condition. Spousal refusal allowed his wife to keep her income

to support their family and for him to become eligible for Medicaid to cover coinsurance for his cancer treatment, prescription drugs, and medical transportation.

IV. Married Adults Who Rely On the Medicare Savings Program to Help with Medicare Out-of-Pocket Costs. Medicare recipients with incomes under 135% FPL rely on **Medicare Savings Programs (MSPs)** to help with Medicare out-of-pocket costs, saving them \$110 - \$134 per month in Part B premiums and qualifying them for “Extra Help” (the federal 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*. For individuals in “QI-1”-- one of the three MSP programs -- the *entire cost* of the benefit is paid by the federal government, with *no state share*. Here are examples of who is helped by being able to use spousal refusal to access Medicare Savings Programs:

Cathy H, age 66, life-long resident of Manhattan’s Lower East Side, was never able to return to her work as a special education teacher after undergoing five rounds of surgery for cervical cancer in 1994. Her Social Security is \$1700 per /month and her husband’s is \$2300/ per month. More than half of his income pays spousal support to his ex-wife, and their rent and living expenses eat up the rest of their income. Her annual drug costs under Medicare Part D without the “Extra Help” subsidy would be \$3300 per /year. With spousal refusal, Cathy qualifies for the Medicare Savings Program without counting her husband’s income. The Medicare Savings Program pays her Part B premium, saving \$110 per month. and qualifies her for the Extra Help subsidy, which reduces her prescription costs to only \$137/ per year.

Mr. K, a Korean-American senior, age 77, living in Flushing, Queens, has been permanently disabled since his advanced prostate cancer metastasized. One of his cancer medications – Zytiga -- *costs \$8,800 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 gives him Extra Help with Part D, reducing his drug cost to \$8.25/month. New York pays NONE of the cost of the “Extra Help” subsidy for his prescriptions – it is fully paid by the federal government. NYLAG helps him renew this benefit every year.

Disabled people under age 65 who have high drug costs particularly need spousal refusal, in order to qualify for Medicare Savings Program and “Extra Help” with Part D. They are not eligible for EPIC.

b. REJECT reducing “Spousal Impoverishment” resource allowance from \$74,820 to \$24,180 and AMEND the Law to Account for Inflation Since the Law was Adopted in 1995
– (HMH Part B § 7).

In 2016, the legislature rejected the Governor’s proposed to reduce the assets that the spouse of a nursing home resident or MLTC member may keep. This proposal should be rejected again. 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 expanded those protections to protect couples where one spouse is enrolled in a Managed Long Term Care plan. 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.

The federal law has always set a ceiling for what states may set as the spouse’s resource allowance. The maximum allowance was originally \$60,000 in 1988, which gradually increased by a statutory cost-of-living adjustment to the current \$123,600. States have an option of setting the resource allowance between a minimum floor of \$24,180 and the maximum of \$123,600 of the couple’s combined assets.

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

- Option 1. Resource allowance as set by the state (between \$24,180 and \$123,600) or
- Option 2. One-half of the couple’s combined assets, now up to \$123,600.

States like Massachusetts and California set the resource allowance at the highest level permitted - \$123,600 -- and build in a cost of living increase. In those states, Option 1 is always greater -- the spouse may always keep up to \$123,600 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 increased it by the federal cost-of-living index***. In the last 22 years, while the federal ceiling has increased to \$123,600, New York’s allowance has stayed flat at \$74,820. Under the current NYS formula, the spouse may keep the greater of \$74,820 or half of the couple’s combined assets, up to \$123,600.

New York’s resource levels already have a disparate impact on couples with lower resources. The budget proposal will only widen this disparity, burdening couples with the least assets. As illustrated in the table below, the proposal will hurt couples with more moderate resources (Couples A – E marked in **red**). It will not affect those with higher resources (couples F – H).

Couple	Spouse’s assets (aside from applicant’s \$15,150)	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	\$24,180
B	\$47,000	\$47,000	\$47,000	\$24,180
C	\$75,000	\$75,000	\$74,820	\$37,500
D	\$100,000	\$100,000	\$74,820	\$50,000
E	\$123,600	\$123,600	\$74,820	\$61,800
F	\$150,000	\$123,600	\$75,000	\$75,000
G	\$248,000	\$123,600	\$123,600	\$123,600
H	\$350,000	\$123,600	\$123,600	\$123,600

New York has one of the highest costs of living in the nation, which is why the legislature has wisely historically opted for a resource allowance above the minimum required by federal law. Reducing the resource allowance will cause impoverishment of spouses on fixed incomes. Moreover, the community spouse needs to keep assets in order to pay his or her own medical expenses, and to prevent the need for Medicaid. Rather than hasten the impoverishment of people with a spouse who is sick or disabled, the State should acknowledge the tremendously increased cost of living and medical costs in New York since 1995 and, like Massachusetts and California, *increase* the spousal impoverishment allowance to the federal maximum, and enacting a statutory adjustment for inflation as set by the federal government.

- 2. REJECT PROPOSED CHANGES TO MLTC that would: Incentivize Institutionalization, Force more people in need of Home Care Services to Seek them from Underfunded Local Social Service Districts, and Limit member choices and Access.**
 - a. Do Not Remove Nursing Home Residents from MLTC plans after 6 months in the Nursing Home – This will Incentivize Plans to Institutionalize High-Need Members Rather than Provide Adequate Home Care. Instead -- Adopt a Community-Based Rate Cell (HMH Part B § 5).**

The Governor proposes to relieve MLTC plans of nursing home costs by disenrolling members from the MLTC plans after 6 months in a nursing home, after which the nursing home would bill Medicaid Fee for Service. We believe the stated purpose of eliminating duplication of care management services is a pretext for other cost-saving goals that will inflict great harm on MLTC enrollees who have the highest need, who seek to remain in their homes and *avoid* nursing home placement. By removing the cost of nursing home care from the plans’ responsibility, plans will have an incentive to place or keep their

high need members in nursing homes, rather than provide them with adequate home care. This will violate the mandate of the Americans with Disabilities Act that states must provide services in the “most integrated setting,” which is the community. The exclusion of nursing home residents from MLTC plans is a band-aid to fix a broken capitation rate structure. Consumer advocates urge support instead of a **community-based rate cell**, which will incentivize plans to provide adequate home care rather than nursing home care, and which will remedy the structural defect in the rate formulas. **Additionally, consumers urge more transparency** from the Commissioner on the capitation rates, how they are calculated, and on the amount of home care and other services plans are providing.

The stated purpose of saving on duplicate care management services may sound reasonable since nursing homes arguably manage their residents’ care. However, the stated rationale does not explain the enormous projected cost savings of this change - \$73.50 million state share the first year and \$122.50 million the next. Care management cost is built into the capitation rates as well as the nursing home rates, and is relatively nominal. It does not explain the projected savings.

We suspect the real goal of the proposal is twofold – to relieve plans of the high cost of nursing home care in order to stabilize the market and prevent more plans from closing, and to reduce State costs based on the unexpectedly rapid increase in MLTC enrollment. While these may be worthy goals, both can be accomplished in ways that do not harm those MLTC members who, because of severe disabilities and chronic conditions, need high hours of home care in order to remain in the community. If the cost of institutional care is removed from the plans’ shoulders, as proposed, but the cost of high-hour home care for those who need it is still borne by the plans, then plans will have the clear incentive to place their high need members in nursing homes.

The State understandably wants to stabilize the market and prevent more plans from closing. When nursing home care residents were mandated to enroll in MLTC plans, the State increased the capitation rates to take into account these added costs – not just the nominal costs of care management but of the full monthly cost of nursing home care. Plans have complained that even with these rate increases, they cannot afford the cost of nursing home care or high-hour home care, which have led several plans to close or withdraw from certain counties. Removing long-term nursing home care from the MLTC plans, however, without addressing the structural problems in the methodology for setting the capitation rates, will still not stabilize the market, because the rate structure still does not incentivize plans to provide high hours of home care for those who need it. As a result, high-need consumers will face even more barriers to obtaining adequate hours of home care than they do now.

We suspect that the high projected cost savings for this proposal results from the expected reversal of the rate increases paid to plans since 2015, which were designed to incorporate the cost of nursing home care. Upon information, this rate increase was approximately \$500 per member per month (PMPM) Assuming a \$500 PMPM rate increase over the then median \$4066/mo capitation rate,⁴

⁴ See U.S. Dept. of Health & Human Services, Office of Inspector General Report, NEW YORK STATE IMPROPERLY

because enrollment in MLTC plans has increased by 61% from April 2015 (123,522 enrollees) to January 2018 (199,000 enrollees), the cost of the increase in the capitation rate due to the nursing home carve-in alone has grown from \$741 million in 2015 to \$1.2 billion in 2018, an increase of \$455 million per year. By removing a reported 26,000 nursing home residents from MLTC plans in 2018, and rolling back the 2015 rate increase that was intended to compensate plans for the nursing home care, the State’s net savings, after offsetting the cost of paying for the nursing home care fee for service, is about \$90 million – roughly what the Executive projects. Clearly, these savings have nothing to do with duplicative care management.

While these savings may be appealing, the methodology is deeply flawed, since it still does nothing to address the **underlying structural rate defects** that deter plans from authorizing 24-hour/day care or other high authorizations for those who truly need it. Consumer advocates fear that relieving MLTCs of responsibility for the cost of nursing home care will create a substantial and dangerous incentive for plans to push members with high needs in the community – those needing 24-hours of care – into nursing homes, rather than approve 24-hour care.

Instead of solving the MLTC structural rate inadequacies by removing nursing home care from the MLTC package, advocates urge that the Department develop a community-based high-need rate cell, which will pay plans an adequate rate to provide 12 or more hours of home care for those who need it because of diseases like Parkinson’s, stroke, dementia, or Multiple Sclerosis. In a side letter negotiated with last year’s budget, the Executive Department of Health committed to exploring separate rate cells or risk adjustments for the nursing home and high cost/high need populations. **DOH has received at least one concrete proposal for a high needs rate cell that shows promise for providing adequate reimbursement to provide home care for those who need the most care.** Before considering either a nursing home rate cell or the proposed removal of nursing home care from the MLTC package, the State should commit to meaningful rate reform that will stabilize the market and maintain New York’s longstanding commitment to providing long term services and supports where people want them – in their homes. Incentivizing the provision of nursing home care, by funding it on a fee for service basis, without also funding high-need home care, will raise serious concerns of violations of the Americans with Disabilities Act, as interpreted in the *Olmstead* decision by the U.S. Supreme Court.

b. Reject the Exclusion of the Lowest need members – Those with a score of 9 or lower on the Uniform Assessment Tool – from MLTC. (HMH Part B § 3).

The proposal would bar from MLTC enrollment those who need fewer hours of home care because of being assessed as less dependent on an aide for everyday activities like bathing and dressing, walking, toileting, or preparing and eating meals. We have three concerns about this proposal.

CLAIMED MEDICAID REIMBURSEMENT FOR SOME MANAGED LONG-TERM CARE PAYMENTS, September 2017, at footnote 1, available at <https://oig.hhs.gov/oas/reports/region2/21501026.pdf>

1. Responsibility for authorizing services for this population will presumably be left to the Local Departments of Social Services (“LDSS”), which have scaled back their operations and home care agencies contracts since MLTC became mandatory, and lack the necessary resources to conduct the individual needs assessments and to provide services.
 2. The exclusion of low-need individuals from MLTC plans leaves plans with high concentrations of high-need members, who, because of financial pressure on plans, are denied the services they need to remain safe in their homes. Capitation rates will also need to be raised because of the higher overall acuity of the members enrolled.
 3. Under another part of the budget proposal, spousal refusal protections will not be available to those married individuals carved out of MLTC who must access home care services on a “fee for service” basis from local districts. Nor are the “spousal impoverishment” protections available in fee-for-service home care. Once again, the specter looms of “community spouses” being forced to divorce their ill spouse, or place their spouse in a nursing home in order to be permitted to retain enough assets and income to meet their own current and future needs. This would bring us back to the days before Congress enacted the spousal impoverishment protections in 1987. Such scenarios could also well violate the *Olmstead* decision.
- c. REJECT Lock-In - MLTC members must continue to have the right to change plans if their plan is providing inadequate or poor quality services (HMH Part B § 4).**

We oppose this change, as member’s ability to “vote with their feet,” and choose a different plan than one they are unhappy with is crucial. The proposal is to lock them into one plan after 30 days of enrollment, if they chose the plan, and 45 days if they were assigned to the plan. The MLTC contract only requires plans to assess a member’s needs by the 30th day of enrollment. The member may not even have received an initial plan of care from the plan by the 30th or 45th day of enrollment, so they do not even have critical information needed to decide whether to stay or switch. If the MLTC program is supposed to be “person-centered” and based on consumer choice, then competition between plans by offering higher quality care or customer service should be encouraged rather than quashed. For this particularly vulnerable population, for whom a personal care aide’s services is a lifeline, and who have so little control over their declining health and abilities, it is critical that these fragile individuals retain the right to switch plans.

d. Do not Disenroll a Member from MLTC Plan if Plan Failed to Provide Services for 30 Days

This administrative proposal would reward an MLTC plan for failing to start services within the first 30 days of enrollment, by disenrolling the member from the plan. We oppose this for several reasons.

First, especially in upstate counties, plans have been known not to provide home care services for *months*, claiming they cannot find a home care provider. The state should be enforcing the plan’s duty under contract and regulations to have an adequate network of providers and addressing the well-

documented home care worker shortage, rather than relieve them of this responsibility by disenrolling the member. Moreover, the prospect of members being disenrolled if they do not receive care could also be used by plans as a pretext to disenroll high-need members, to avoid the high cost of their home care.

Second, as stated in the section above opposing lock-in of members after 30 days, plans are not even required to conduct the initial assessment until the 30th day after enrollment. Many new members will not have services started until after 30 days.

Third, advocates understand that the Executive does not want to pay plans its full monthly capitation rate for a month in which the plan fails to provide home care. A similar issue arises when a member is hospitalized for more than 45 days, when the MLTC contract requires disenrollment from the plan. In both cases, the better policy would be to *suspend* the member's enrollment in the plan, and *not terminate* enrollment, or to retain enrollment and claw back payment to the plans for those months. Either way allows the enrollment to be reinstated more quickly than if the member is disenrolled, then has to go through a lengthy reenrollment process.

Also, the Commissioner should consider pro-rating capitation payments for periods of less than a month. If the member is not receiving services for 15 days, or is in the hospital for 45 days, then claw back a proportional part of the capitation payment.

e. Reject Contracting limits that would set a cap of 10 licensed home care services agencies an MLTC plan may contract with.

This cap will increase barriers to consumer access, as many plans – particularly upstate -- already do not have an adequate network of home care provider agencies to provide authorized services. See, eg. Fair Hearing No. # 7293959J, dated July 15, 2016 (Ulster County); No. 7103015Y, dated Nov. 7, 2015 (Rensselaer County) (both available at <http://otda.ny.gov/hearings/search/>). Consumers have rights under federal regulations to adequate networks of providers. 42 C.F.R. §§ 438.206. An arbitrary limit of 10 agencies, taking no account for the size of the plans nor of the agencies, is inviting severe capacity issues, threatening access for consumers.

3. Preserve “prescriber prevails” in the Medicaid fee-for-service and managed care programs.

NYLAG opposes the Governor'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 Governor 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 as medically necessary: 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. (Part D, § 4-5).

Because of their familiarity with 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. 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.

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.

4. NYLAG GIVES QUALIFIED SUPPORT for increasing the Medicaid cap on Physical Therapy (PT) visits from twenty visits per year to forty visits per year, but urges that an exception process be implemented to waive the cap when medically necessary, and that any relief from the 20-visit cap should apply for Speech and Occupational Therapy visits as well. (HMH Part A, §5).

While we support relief from the harsh 20-visit cap on physical therapy, NYLAG proposes several improvements in the proposal. First, this long-needed change should not be contingent on savings from performance targets in the bill. Second, rather than raising the flat annual cap, it is time for New York to enact a **medical necessity exception** in New York Social Services Law § 365-a(2)(h), which will allow those who need more than the cap to get the therapy they need. Third, any cap or exception should apply to Speech and Occupational Therapy, as well as Physical Therapy.

Since enacted 5 years ago, the 20-visit cap, accident victims have suffered in pain, without the means to regain full functionality, and individuals who have undergone surgery have been unable to restore functioning. While raising the limit to 40 visits per year would help, it is not sufficient for an individual with the bad luck to have two incidents requiring physical therapy in one year – such as these individuals:

- A 56-year old woman who, on Nov. 2, 2016, fell from a bus and had physical therapy for her left hip in early 2017. In mid-2017, her doctor discovered that her right hip was also injured. Also in 2017, she was rushed to the hospital with a diagnosis of spinal stenosis and compressed

disc in her lower back. Because of the flat cap, she was unsuccessful in winning a hearing challenging her managed care plan's denial of more than 20 visits in 2017.⁵

- A man who received physical therapy after shoulder surgery was denied any physical therapy to recover from ankle surgery he had several months later.⁶

If visits are increased to 40 for PT, they should be increased the same for Speech and Occupational Therapy, as shown in this example:

- 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.⁷

Here are other examples of how the physical, occupational, and speech therapy caps are blocking access to medically necessary treatment and causing real harm to New Yorkers:

- A Monroe County resident with hip dysplasia who had reparative surgery to her left and right hip, followed by physical therapy, still needed further surgery to remove the screws in her right hip, but could not have the surgery unless she could have physical therapy afterward. Her treating physical therapist opined that "She has been doing well. She has been going to therapy. Her pain has been decreasing, but she worried that her screws have become permanent." She lost the hearing seeking additional physical therapy.⁸
- A 47-year-old woman in Rockland County had used up the 20 physical therapy visits to strengthen her left forearm before hand surgery, as recommended by her surgeon, and now needed at least 30 more physical therapy sessions after surgery on her hand. Despite testimony that she suffers daily pain, is unable to flex her fingers at all so can do no activities with her hand, making her totally dependent on her husband, and must wear a protective cover on her hands to keep from injuring herself, she was denied any additional physical therapy.⁹
- A 50-year old woman had recently been found disabled by the Social Security Administration for Multi-System Atrophy, a disease similar to Parkinson's, which affects her coordination and gait and has caused her to fall with some frequency. These symptoms are alleviated by

⁵ Decision after Fair Hearing, # 7617456H, available at http://otda.ny.gov/fair%20hearing%20images/2017-12/Redacted_7617456H.pdf dated Dec. 12, 2017 (NYC) (last visited 1/22/18)

⁶ 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 1/22/18)

⁷ 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 1/22/18)

⁸ Decision after Fair Hearing, #7622851M, available at http://otda.ny.gov/fair%20hearing%20images/2017-12/Redacted_7622851M.pdf - dated Dec. 8, 2017 (Monroe County) (last visited 1/22/18)

⁹ Decision after Fair Hearing, #7613422K, available at http://otda.ny.gov/fair%20hearing%20images/2017-11/Redacted_7613422K.pdf ,, dated Nov. 10, 2017 (Rockland County) (last visited 1/22/18)

physical therapy. Due to the cap, the fair hearing rejected her appeal of her managed care plan's denial of additional physical therapy. She will not receive Medicare for two years after she begins receiving Social Security Disability benefits, and until then she'll be barred from receiving necessary physical therapy after meeting the cap.¹⁰

- 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 based on the cap, despite the student experiencing increased pain and difficulty walking, trouble sleeping, and difficulty climbing the stairs to her home.¹¹

The above are just a handful of examples of the absurd consequences of New York Medicaid's 20 visit cap on physical, occupational, and speech therapy. 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. Some would benefit if the cap was increased to 40, but for others it would still not be enough, or would not help at all because they need Speech or Occupational therapy.

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.¹² 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 year cap on rehabilitative physical, occupational, and speech therapies, and an additional 60 visits per year habilitative services benefit for the three therapies.¹³ Habilitative services include therapies to maintain or prevent deterioration in functioning. Notably, of the ten group insurance plans New York looked at when considering what plan would serve as its base benchmark plan, only one used a 20 visit per year limit.¹⁴

¹⁰ Decision after Fair Hearing, # 7559210R, available at http://otda.ny.gov/fair%20hearing%20images/2017-9/Redacted_7559210R.pdf, dated Sept. 6, 2017 (NYC) (last visited 1/22/18)

¹¹ 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 1/22/18)

¹² 42 U.S.C. § 1396r-5l(g).

¹³ New York 2017 EHB Benchmark Plan, p. 3. Available at <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/NY-BMP.zip>.

¹⁴ 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.

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.¹⁵ Habilitative services include therapies to maintain or prevent deterioration in functioning. In 2017, these plans shifted 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.¹⁶

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, or enact a medical necessity exception, and restore Medicaid recipients' ability to maintain and improve their functioning so that they can participate to their maximum capacity in daily life. Alternatively, but not preferably, the same increase in the cap for physical therapy should apply to speech and occupational therapy.

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

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¹⁵ 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 1/22/18)

¹⁶ New York 2017 EHB Benchmark Plan, p. 3. Available at <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/NY-BMP.zip> (last visited 1/22/18)