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 2022-2023 EXECUTIVE BUDGET

TOPIC: HEALTH/MEDICAID

Submitted by
Valerie Bogart, Esq.
Director, Evelyn Frank Legal Resources Program
New York Legal Assistance Group
100 Pearl Street, 19th floor
New York, NY 10004
Direct Dial 212.613.5047
vbogart@nylag.org

The New York Legal Assistance Group (NYLAG) uses the power of the law to help New Yorkers experiencing poverty or in crisis combat economic, racial, and social injustice. We address emerging and urgent needs with comprehensive, free civil legal services, financial empowerment, impact litigation, policy advocacy, and community partnerships. We aim to disrupt systemic racism by serving clients, whose legal and financial crises are often rooted in racial inequality.

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NYS SFY 2023-2024 BUDGET – Heath Access Priorities

1. **MEDICAID ELIGIBILITY EXPANSION –** ASSET TEST, MBI-WPD, HEALTHCARE4ALL -- COVER UNDOCUMENTED IMMIGRANTS, FAMILIES AND CHILDREN
2. **HOME CARE STAFFING SHORTAGE –** REJECT CONSUMER-DIRECTED PERSONAL ASSISTANCE PROGRAM (CDPAP) CUTBACKS & ENACT FAIR PAY FOR HOME CARE
3. **MLTC PERFORMANCE STANDARDS & CONSUMER PROTECTIONS**
4. **REPEAL MRT II CUTS -** HOME CARE RESTRICTIONS AND "LOOKBACK"
5. **OTHER MLTC CONSUMER PROTECTIONS**
6. **EXPAND MCCAP PROGRAM – MEDICARE COUNSELING & ADVOCACY**
7. **PROTECT PEOPLE WITH DEVELOPMENTAL DISABILITIES**

I. MEDICAID ELIGIBILITY EXPANSION

1. Expand Coverage of Undocumented Immigrants Age 65 and Over, and Include All Immigrants in the Essential Plan (Part H) –

While we support expansion of the Essential Plan (EP) to include those up to 250% FPL, this should include undocumented immigrants. (S.2237, Rivera/A.3020, Gonzalez-Rojas). We oppose the one-year delay of last year's enacted expansion of Medicaid eligibility for undocumented seniors age 65 and over. The delay will harm thousands of older persons as well as contribute to public health risks. There are roughly one million NYS residents who do not have any form of health insurance coverage -- the "last mile" of achieving universal coverage that has significantly shrank in the last decade.

In 2022, NYLAG's LegalHealth unit, a medical-legal partnership, helped 206 undocumented immigrants attain Medicaid eligibility. This was one-third of all LegalHealth clients who needed help with Medicaid. Here are examples of people who were fortunate to get our legal help to obtain Medicaid through establishing PRUCOL status, such as by obtaining Medical Deferred Action. Unfortunately, many more people do not get this help, which takes time and expertise – but would now be eligible without delays if EP was expanded – with federal funds at no cost to the state.

Although he was receiving dialysis, Fred's advanced kidney failure and heart condition were still worsening. *Born in Barbados, Fred, age 59, was referred to LegalHealth at NYC Health+Hospitals to qualify for a desperately needed heart and kidney transplant – which was not covered by Emergency Medicaid, the only coverage available for undocumented immigrants. Fred is a pillar in his community -- certified in Mental Health First Aid, a pastor at his church, and the single father of son who has joined the military to pursue a career in the medical field (and attributing his goal of helping others to his father). The NYLAG attorney gathered statements of those who loved Fred and submitted the necessary paperwork for a Medical Deferred Action. The submission was successful, and Fred recently received a heart-kidney transplant. He is recovering at home.*

Maria was only given medication by Montefiore hospital to treat her advanced liver failure because a transplant was not covered by Emergency Medicaid *– her only coverage since she was undocumented. As her condition worsened, the hospital referred her to NYLAG's LegalHealth program, which filed for Medical Deferred Action and established PRUCOL status for Maria. With full Medicaid coverage, Maria was able to receive her life-saving liver transplant and is currently recovering.*

2. INCREASE ASSET TEST FOR AGE 65, BLIND & DISABLED –

We applaud the Governor's initiative last year that increased the income limit for those Age 65+, Blind or Disabled. However, the asset limit remained at 1.5 times the annual income limit. Repeal of the asset test is ***essential to eliminate racial disparities*** in health care access. The current asset rules are biased against people of color, who statistics show are less likely to own homes and retirement funds, assets that are given special treatment as exempt from the asset limit, while cash assets count. See letter here. As a step to addressing these inequities, the asset test should be increased to six times the annual income limit.

3. Expand Medicaid Buy-In for Working People with Disabilities (MBI-WPD)(Part N)

We support – with qualifications -- the Governor's proposal to expand this program that enables working people with disabilities to receive crucial Medicaid home care and other services they need in order to continue working – services that are not available through commercial employer-based health insurance.

- We support aspects of this proposal -- lifting the age limit of **65** and exempting income and resources from the legally responsible relative (spouse)
- We object to the excessive **copayments** for those with income above 250% FPL.
- While the proposed increase in the asset limit to $300,000 is commendable, NYS should follow California, Massachusetts, Colorado and Texas and repeal the asset limit for this unique program.
- To promote the ability of working people with disabilities to support their dependent children, the income limit should be based on the Federal Poverty Level for the family of the size involved, as used for the Part D Low Income Subsidy. 42 U.S.C. 1395w-114(a)(1); 42 C.F.R. 432.772.
- The cap of 30,000 members should not include those who qualify for MBI-WPD under the existing criteria set forth in SSL 366, subd. 1(c)(5) and (6) and SSL 367-a, subd. 12.

I. Expand Medicaid eligibility for families and children

- **Continuous eligibility from birth to Age SIX** – Build on New York's existing one-year of continuous eligibility for those under age 65 to ensure that young children keep Medicaid during their critical developmental years. Oregon was approved for this expansion last year.

- **Expand Post-partum care until child reaches age SIX –** Build on last year's expansion of Medicaid post-partum coverage from 60 days to one year by expanding coverage until the child is age SIX. This would ensure continuity of care.

II. HOME CARE STAFFING SHORTAGE – PROPOSED CONSUMER-DIRECTED PERSONAL ASSISTANCE PROGRAM (CDPAP) CUTBACKS WILL WORSEN THE CRISIS

1. **Retain Wage Parity for CDPAP (Part I Sec. 15) –** The Governor proposes to roll back important wage parity rights for CDPAP personal assistants in NYC, Long Island, and

Westchester. This will reduce wages about $4 per hour – making it virtually impossible for consumers to recruit and retain people to provide their crucial home care. Swapping in a partial subsidy to purchase health coverage on the NYS of Health marketplace is no substitute for a decent hourly wage, especially for workers who might have their own health coverage through other work, Medicare, Medicaid or the Essential Plan. For those consumers forced to give up their right to direct their own care through CDPAP, and switch to traditional Personal Care, the severe worker shortage will leave thousands of consumers without home care.

2. **Fair Pay for Home Care** -- Last year a moderate $3 increase in home care worker wages (over 2 years) was enacted, but we urge enactment of this bill that would increase wages to 150% of the regional minimum wage. Sustained changes are needed to improve recruitment and retention of direct care workers. Further, the State has failed to demand accountability from managed care plans for the $500 million they received to pay the wage increases. Stories are legion about the plans failing to pass through this funding to home care agencies and CDPAP fiscal intermediaries, depriving them of the funds needed to pay this increase.

III. MLTC PERFORMANCE STANDARDS, TRANSPARENCY & CONSUMER PROTECTIONS

Part I would give the Commissioner authority to select MLTC plans through a competitive bidding process, if it is determined that a sufficient number of plans fail to meet performance standards that the Commissioner would establish. Performance standards should be expanded to include key consumer protections, and data should be publicly released that holds plans accountable for providing quality care in the community.

- **LHCSA Contracting Limits – Consumer Protections Needed.** The performance standards specified in the bill are not enough, such a measuring plans' compliance with 2018 amendments that required plans to reduce the number of licensed home care services agencies (LHCSA) with which they contract.[1] This law was enacted and first implemented before COVID-19 devastated the home care workforce. These contract limitations now contribute to the ongoing dire workforce shortage, and disrupt continuity of care. If these contract limits are to be used to measure MLTC performance, consumer protections must be added to ensure continuity of care and access:

    - Consumers, rather than solely plans, should have the right to request an exception from the numerical limits, or to appeal the denial of an exception, if necessary to ensure adequate access and meet cultural and linguistic needs.

    - The temporary extension of a LHCSA contract for continuity of care should be extended from 3 to 12 months, and additionally while a consumer's appeal of the denial of an extension is pending.

    - The contract limitations should be suspended while the Commissioner develops metrics to track network adequacy and timely staffing of cases, which is currently not tracked. The limitations would not be reinstated until metrics are developed, and then only when a plan has been determined to meet these benchmarks.

[1] Section 9–a of Part B of Chapter 57 of the Laws of 2018 added a new paragraph (j) to subdivision (7) of Section 4403–f of the New York Public Health Law.

- **Performance standards should include Quality Measures Recommended by CMS to Track "Rebalancing" indicators and Staffing Capacity – Data Should be Publicly Reported** --Are plans keeping members out of nursing homes and successfully transitioning new members from nursing home stays? Long-term nursing home care was "carved out" of the MLTC benefit by law in 2018 and implemented in 2020. Yet no additional plan reporting has been required to monitor whether more consumers are being permanently placed in nursing homes.
    - Performance measures should track the **number of unstaffed cases** In light of staffing shortages exacerbated by COVID
    - All data should be disaggregated by race and ethnicity.
    - **Financial and service data from annual Managed Medicaid Cost and Operating Reports (MMCOR[2]) should be publicly posted in an interactive format that enables comparison between plans and regions.** The NYLAG MLTC Data Transparency Project is a model for how this can be done and why it is necessary to hold plans accountable for how billions of Medicaid dollars are spent.[3] For example, if a plan is providing comparatively few hours of home care to most members,[4] while admitting more members to nursing homes, this flags potential *Olmstead* violations.

    - **Rebalancing from Nursing Home to Community Care** -- Performance standards, as well as public online data and consumer guides, should track the percentage of expenditures by each plan for home and community-based services compared to nursing home services. Regional data is critical because, as shown in the chart below, "Aggregate state-level rebalancing measures mask differences across populations and regions within states."[5]

Regional Differences in Percentage of Plan Enrollees in Nursing Facilities and Percentage of Service Expenditures on NF Services - 2017

	% Enrollees in Nursing Facility	% Service Expenditures on Nursing Facility
NYC (includes L.I & Westchester)	6.0%	13.83%
Mid-Hudson/No. Metro (6 counties)	19.3%	34.41%
NE-Western (16 counties)	**37.6%**	**61.44%**
Rest of State (32 counties)	**47.7%**	**71.74%**
Statewide	**10.9%**	**20.07%**

Source: Column 1 from MMCOR Exh. A1 and A2, 2017 on file with NYLAG. Columns 2 from https://nylag.org/mmcor-service-expenditures/ which use 2017 MMCOR data.

[2] Public Health Law § 4403-f, sub. d 7(a); 10 NY NYCRR § 98-1.16(f - g).

[3] https://nylag.org/MLTCdatatransparency/ and see Project report at https://nylag.org/wp-content/uploads/2022/09/MMCOR-Report-FINAL.3.pdf at pp. 43-48.

[4] The visualization at https://nylag.org/home-care-member-years-by-hourly-category/ shows the MMCOR data for 2017 and 2018 of how many members each plan authorizes to receive home care services in seven ranges of hours per month from high to low.

[5] See Deborah J. Lipson, *Measures of State Long-Term Services and Supports System Rebalancing: HCBS Quality Measures Issue Brief*, Mathematica, Nov. 2019, pp. 6-7, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/hcbs-quality-measures-brief-3-rebalancing.pdf.

IV. Repeal MRT II Home Care Restrictions and "Lookback" enacted in SFY 2021:

1. **Repeal the restrictive minimum of three Activities of Daily Living (ADL) required for eligibility for Medicaid personal care and consumer-directed services -- S328** *(Rivera)* -- These ADL thresholds discriminate against people with developmental disabilities, traumatic brain injury, visual, and other impairments. These individuals qualify for home care only if they need *physical* assistance with 3 ADLs, even though the nature of their impairments causes them to need *cueing and supervisory* rather than hands-on physical assistance. Yet people with dementia will qualify if they need *cueing and supervisory* assistance with 2 ADLs. Such blatant discrimination based on the type of diagnosis is unlawful.

    - The minimum ADL requirements will also eliminate the longstanding "**Housekeeping**" program entirely. "Housekeeping" is a type of Personal Care service that provides an aide for a maximum of 8 hours/week for those who can bathe and dress themselves but need help shopping, cleaning, or doing laundry because of their disability. Since personal care eligibility will now require two or three ADLs, this service will no longer be available – putting a person with a disability at risk from a fall or other injury that would lead to higher cost care.

2. **Repeal or improve the "Independent Assessor" --** This massive and problem-ridden bureaucracy operated by Maximus has, since implemented in May 2022, created huge delays and obstacles to accessing Medicaid home care. See https://medicaidmattersny.org/wp-content/uploads/2022/11/Joint-Consumer-Advocate-Plan-Association-Letter-on-NYIA-10.27.22-final.pdf. If not repealed, protections should be enacted to mitigate some of the harm:

    - NYIA should be scaled back to apply only to MLTC, to eliminate confusion, barriers and delays for the populations added – those exempt or excluded from MLTC seeking services from the local districts or from their mainstream Medicaid managed care plans
    - Procedure for consumer to submit medical records from their physician and other providers to be considered by all assessors, the plan or local district
    - NYIA Contractor must schedule and conduct assessments:
        - If Medicaid application is pending but not yet approved
        - When requested by any family member, attorney, care manager, or other person assisting the consumer -- without requiring signed authorization.
        - Within deadlines to be specified by statute, with penalties for non-compliance.
    - Require public dashboard with monthly data including number of assessments requested and conducted in person and by telehealth, number of days from request until conducted, number of assessments requested and conducted in primary language of consumer, call center hold times and language capacity, and outcomes of assessments broken down by approval or denial of MLTC enrollments, Mainstream service requests, and local DSS service requests, and reasons for denial. All above broken down by county or region.

3. **Repeal the lookback and transfer penalty for home care**. NYS had never exercised the federal option of imposing a lookback and transfer penalty for community-based care – until enacting a 30-month lookback in 2020. Implementation has been delayed because of protections during the

Public Health Emergency – and it should be repealed. Wealthy people will use trusts and other Medicaid planning techniques to circumvent these rules, but low income people will be denied home care for modest transfers. Those with no assets to transfer will face long application delays from the added paperwork demands and resulting hardship.

V. Other MLTC Consumer Protections –

- **Auto-Enrollment into MLTC** once approved by NY Independent Assessor. Gov. Cuomo vetoed an earlier version of this bill in 2019 (A7578 (Gottfried)/ S5485 (Rivera)). This would auto-assign people found eligible into MLTC plans just like happens in mainstream managed care. Reintroduced as **S4965/A155** at https://tinyurl.com/NYrecert (passed Senate, died in Assembly Ways & Means). This would reduce the cherry-picking behavior by which plans avoid enrolling high-need consumers because of the higher cost of their care.

- **Automatic ex parte Medicaid renewals for those in MLTC plans or otherwise receiving home and community-based services (HCBS)** - In late 2019, Gov. Cuomo vetoed the same bill described above, which also would have required automatic recertification of those recipients on fixed incomes, for whom third-party verification would establish a high likelihood of eligibility, and for HCBS recipients, for whom suspension because of erroneous termination in the redetermination process jeopardizes health and well-being. In vetoing the bill, reintroduced as **S4965/A155** at https://tinyurl.com/NYrecert, the Governor claimed that CMS would not allow it and that the state would lose FFP. However, CMS proposed "streamlining" regulations could pave the way for this change (see https://www.cms.gov/newsroom/fact-sheets/streamlining-eligibility-enrollment-notice-propose-rulemaking-nprm);.

- **Continuity Of Care Protections Needed if Plans Close Due to any Market Alteration or Competitive Bidding, or when Plans Reduce LHCSA Contracts** - Continuity of care rights for consumers must be strengthened if their MLTC plan closes or is acquired by or merged with another plan, or if they need to change plans to retain a longtime aide when the plan drops a LHCSA contract. The receiving plan should be prohibited from reducing services unless it can prove that the enrollee's medical condition or social circumstances changed, making the amount that was previously authorized no longer appropriate or necessary.

VI. Protect People with Developmental Disabilities

We oppose extending the authorization for 5 years to move services for people with developmental disabilities to Medicaid managed care. There is no evidence that this change would be beneficial for consumers. Studies have shown no savings associated with managed care for this population and no improvements in services. NYLAG has extensive experience advocating for consumers in managed care and MLTC plans – including those with developmental disabilities who have not opted out of managed care. They face severe barriers to access and only an empty promise of "care management." We support the proposal to create an ombudsprogram for this population.

VII. Expand Funding for the Managed Care Consumer Assistance Program (MCCAP)

NYLAG is one of six organizations in the MCCAP network providing vital counseling and advocacy for low-income Medicare beneficiaries desperate to reduce their out of pocket costs. A $1 million increase above the $1.76 million appropriation is needed to cover rising costs and meet increased demand.

For more information contact: Valerie Bogart 212-613-5047 vbogart@nylag.org