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 2019-2020 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

February 4, 2019

Founded in 1990, the New York Legal Assistance Group 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's wide range of legal services for low-income New Yorkers includes access to health care and community-based long-term care for older persons and people with disabilities, so that they can live dignified, independent lives, and 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 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:

OPPOSE the following cutbacks in Medicaid eligibility services that will hurt the poorest New Yorkers **PAGE**

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

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 and nursing homes,, since federal law and the 1115 waiver require it,[1] it is still needed in other circumstances.

A. MYTH: Because MLTC members have spousal impoverishment protections, they don't also need "spousal refusal."

FACT: Spousal Refusal is Needed to Apply for Medicaid in Order to Enroll in MLTC, since Spousal Impoverishment protections don't take effect until after enrollment. . Though spousal refusal and spousal impoverishment protections are available ***after*** a person enrolls in MLTC, "spousal refusal" is needed ***before*** then, when 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. The same is true if the spouse's income exceeds the low

[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. The ACA provision expired 12/31/19. As of 1/17/19, bills were passed in the House and Senate to extend the provision, awaiting the President's signature.

[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).

regular 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	- Medicaid Limit	-22,200	-$1,267	
Mary's Medicaid application is DENIED with **NO spousal refusal**	**EXCESS RESOURCES or Excess Income**	**$53,800**	**$2,233**	The Medicaid application is **DENIED** for excess resources. Mary has a $2,233 spend-down she can't 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** Her assets alone are within limits ($15,150).	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.
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	BOB can keep his $60,000 savings since < $74,820 Spousal impoverishment limit. Mary can keep hers. INCOME: Each can keep their own. Mary has only a $19 spend-down.

[3] 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).

B. **MYTH: NEW YORK IS MORE GENEROUS THAN OTHER STATES IN FINANCIAL ELIGIBILITY**.

FACT: It's true that in 1995, New York opted for the maximum spousal impoverishment resource level available under federal law. However, New York never enacted a cost of living adjustment for this allowance. If it had, the resource allowance would now be the current federal maximum of $126,420. Without those COLA increases, New York's resource limit for a spouse of a nursing home or MLTC member is only $74,820. New York's failure to opt for the maximum allowance, despite the high cost of living in New York City and other areas of the state, forces spouses to use "spousal refusal." Other states such as Massachusetts and California with high costs of living opt for the highest allowance with the COLA increase.

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

a. 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 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.

b. Terminally ill Home Hospice recipients and others who need home care but are excluded from MLTC – they cannot benefit from spousal impoverishment protections, so depend on spousal refusal. They access home care from their local district rather than an MLTC plan.

c. Married Adults Who Rely on Medicaid to Help with Medicare Out-of-Pocket Costs. Lev is a 67 year old Russian immigrant living 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, who arrived in the U.S. earlier, supports them by earning $2100/month gross as a home care aide. 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 Medicaid to cover coinsurance for his cancer treatment, prescriptions, and medical transportation.

d. 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** (**MSP**s) to help with Medicare out-of-pocket costs, saving them $110 - $135.40 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 using spousal refusal for 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.

Married people with disabilities under age 65 who have high drug costs are not eligible for **EPIC**. Spousal refusal qualifies for Medicare Savings Program and "Extra Help" with Part D.

2. 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 B, § 3).

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 harm.

3. OPPOSE reducing Medicaid benefits for low-income Medicare beneficiaries who rely on Medicaid or Qualified Medicare Beneficiary (QMB) benefits to make Medicare affordable; cuts will reduce access to preferred providers because fewer will accept Medicaid.

Most seniors and people with disabilities have Medicare, but Medicare is expensive, with many out-of-pocket costs. Those with means can afford a private *Medigap* supplemental policy that pays these out-of-pocket costs, but with premiums over $250/month, the lowest income Medicare beneficiaries cannot afford them. Instead, the lowest income Medicare beneficiaries enroll in the Qualified Medicare Beneficiary (QMB) program or Medicaid, which *used to* assure meaningful access to Medicare services by paying the Medicare deductibles and cost-sharing, as well as for Medicare Part B premiums. However, federal law allows states to limit their cost-sharing assistance by paying the "lesser-of" Medicaid or Medicare rates, which New York has done since 2015.[4] Meanwhile, federal law

[4] For the 30% of Medicare beneficiaries who are in Medicare Advantage plans instead of in Original Medicare, Medicaid payment of the coinsurance, since the 2016 state budget law, is limited to 85% of the coinsurance or copayment due under the plan.

also bars providers from "balance billing" QMB enrollees for any unpaid cost-sharing.[5] As a result, a provider has to absorb the loss from unpaid Medicare coinsurance. This leads many providers to *refuse to serve Medicaid recipients or QMBs*, thereby reducing access to routine and specialty health care among QMB and Medicaid enrollees.

Example:	Medicare approved charge is	$185	Medicaid rate is $100
	Medicare pays 80%	$148	
	Coinsurance (20%)	$37	Medicaid pays **none** of the coinsurance

because the Medicaid rate is less than the amount Medicare paid. Provider may not legally bill the patient for the coinsurance – but if the provider does not accept Medicaid, the provider may refuse to serve the individual altogether – threatening reduced access for low income Medicare beneficiaries.

Now the Governor proposes to cut NYS Medicare cost-sharing assistance even more in two ways:

1. **Annual Deductible** -- Each year, a Medicare beneficiary must first meet the Part B deductible. This means that Medicare will not begin paying any doctor's or other Part B bills until the beneficiary has incurred bills for which the Medicare approved charges total **$185** (2019). The beneficiary is liable for 100% of the Medicare approved charge until the deductible is met. In the example above, if this service was the first one received in the calendar year, Medicare would not pay any of the bill. The bill meets the Part B deductible of $185, so Medicare would start paying bills following this one. What will Medicaid pay for a NY QMB or Medicaid recipient? In the example above:
    a. **NOW** - Medicaid pays the entire Medicare approved charge of $185, so that the beneficiary meets the annual deductible, and provider is paid in full.
    b. **PROPOSED change** – Medicaid would pay only the Medicaid approved rate of $100. While the Part B deductible is met by the Medicare approved charge of $185, even if unpaid, the provider must absorb the loss of $85. This loss may lead the provider to refuse to accept Medicaid at all. Though providers may not legally bill the recipient for the balance, in reality they do, causing stress for the elderly and a rift between provider and patient.

2. Psychologist and Ambulance Services No Longer Held Harmless under Gov's Proposal

In 2016, an exception was enacted ensuring that Medicaid paid the 20% coinsurance at the full Medicare approved rate for two critical services – **psychologists** and **ambulances**. This exception protected all Medicare beneficiaries who were QMB or Medicaid recipients, regardless of whether they had Original Medicare or Medicare Advantage. Now, the Governor proposes to repeal those exceptions. People with Medicare already have difficulty finding a psychologist who accepts

[5] Section 1902(n)(3)(B) of the Social Security Act (the Act), as modified by section 4714 of the Balanced Budget Act of 1997; see CMS Medicare Learning Network Bulletin, Prohibition Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program, rev. June 2018, available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1128.pdf

Medicare, a problem that will only worsen as these providers see their reimbursements drop for patients with QMB or Medicaid, since the coinsurance will not be paid.

Also, ambulance companies, some of which already exhibit aggressive billing practices, will likely continue to bill QMBs for cost-sharing, despite federal protections, since they will now face lower reimbursement. In addition, lower reimbursement will make it difficult for those who require regular ambulance transportation—such as those who are homebound and require dialysis—to access the transportation they need to get care. This will be especially true in rural areas where fewer ambulance companies operate.

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The specter of QMB beneficiaries having reduced access to providers willing to treat them is not just speculative. In a July 2015 report, the U.S. Center for Medicare & Medicaid Services (CMS) confirmed finding these patterns in research studies. See "*Access to Care Issues Among Qualified Medicare Beneficiaries.*"[6] The harm from the proposed reduction in reimbursing for the full Medicare Part B deductible will impact access to primary care physicians and specialists, and many other health providers. The removal of the exception enacted in 2016 for two critical services -- ambulance and psychologists – only compounds the harm.

4. OPPOSE giving unfettered discretion to the Commissioner to determine which over-the-counter medications and supplies Medicaid will no longer cover -- and OPPOSE increase in copayments for these items from 50 cents to One Dollar.

The proposed budget would cut access to over-the counter medications and supplies in two ways.

First, it would authorize the Commissioner to select which medications and supplies would no longer be covered and publish the changes by regulation with NO opportunity for the public to submit comments. With so many medications that formerly required a prescription now available over-the-counter, many over-the-counter medications are vital treatments for various chronic and acute health conditions, from antacids and acid reducers for reflux disease and ulcers, laxatives, and stool softeners, anti-diarrheals, cold and allergy remedies, and pain relievers. Such carte blanche authority to the Commissioner should be rejected. Any specific changes to the list of covered drugs and supplies should be proposed through legislation or rulemaking with a full opportunity for public debate.

Second, it would increase copayments on these non-prescription medications and supplies from 50 cents to One Dollar. While this may seem like a nominal amount, it is important to remember that these costs are paid by the poorest New Yorkers – those who rely on public assistance or Supplemental

[6] Available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf.

Security Income (SSI). Research has shown that copayments deter low-income people from accessing health care, leading them to skip doses or stop taking a medication altogether.

If increases in copays are enacted, the Commissioner must enforce federal protections that require pharmacies and other suppliers to provide the medications without collecting the copay if the recipient has an inability to pay. Though this law is on the books, providers and consumers need to be reminded about it, and the law must be enforced.

ALTERNATE COPAY PROPOSAL: If increases in copayments must be considered, the state could replicate the Medicare Part D "Extra Help" tiered cost sharing scale, which charges those Medicaid recipients with incomes over 100% of the Federal Poverty Line higher copayments than those with incomes under that level. Those with incomes over 150% FPL pay more. See tier chart for 2019 at https://www.ncoa.org/wp-content/uploads/part-d-lis-eligibility-and-benefits-chart.pdf. Since some Medicaid recipients have higher incomes, so have a "spend-down," a tiered copayment structure makes sense. The poorest with incomes under 100% FPL should not have copays raised from the current level.

5. OPPOSE proposed restructuring of Consumer Directed Personal Assistance Program (CDPAP), which will result in reduced access to these crucial home care services.

The wholesale changes to the CDPAP program (Part G, Sec. 2-4) threaten access to consumer-directed services both by drastically reducing the number of CDPAP fiscal intermediaries (FI), and by reducing the payment to CDPAP FI's for the costs paid by FI's for worker's compensation and other payroll deductions and overhead costs. If payment is inadequate, FI's will close down – including those with extensive experience and track records of providing excellent services.

New York's CDPAP program has been a national model for enabling consumers with disabilities to direct their own care. CDPAP has always been a cost-saver, since the personal assistants are allowed under the state Education Law to perform "skilled tasks" which are not permitted for traditional personal care or home health aides. Without access to CDPAP, these tasks would have to be performed by a registered nurse or LPN, at a far greater cost.

In the 2017 State budget, a new authorization process for FI's was established, requiring all FI's to apply to the Commissioner for an operating license. Nearly two years after enactment, applications have been filed and the first authorizations are just being issued. This licensing process should be given a chance to continue and winnow the number of FI's and close those that fail to meet the criteria. This is a far more rational process of selection than what is now proposed – which would allow only a few of the existing FI's to survive, selected in an arbitrary way.

Especially upstate, where the home care worker shortage is most severe, CDPAP has played a critical role for MLTC plans to staff authorized home care for members. There is a well-known shortage of

both licensed agencies and workers in rural areas and small towns. MLTC plans even pressure members to accept CDPAP when they would prefer traditional care, because the plans simply cannot staff the cases. Reducing the number of CDPAP FI's in these areas would lead to reduced access for home care services.

6. OPPOSE regulatory changes that, in the name of "flexibility" for managed care plans, would repeal regulations that bar managed care plans from reducing home care services arbitrarily.

Though not in the Article VII bill as a statutory change, the Governor proposes to repeal longstanding state regulations that bar managed care plans from reducing home care services previously authorized unless the recipient's medical condition or other circumstances have improved in a way that lessens their need for home care. The change is purportedly needed to give plans "flexibility."

The referenced regulations are Section 505.14(b)(5)(c) of Title 18 of the NY Code of Rules and Regulations. These regulations were added as part of a settlement of a federal class action, after the court issued a preliminary injunction. See *Mayer v. Wing*, 922 F. Supp. 902 (S.D.N.Y. 1996). The *Mayer* lawsuit challenged a pattern of arbitrary reductions in hours of personal care services by the NYC Medicaid program. The federal court held that once Medicaid home care services were authorized, they could be reduced only if a change had occurred in the individual's medical condition or social circumstances, or if a mistake had been made in the previous authorization. Otherwise, an arbitrary reduction violated due process rights.

Twenty years later, managed care and MLTC plans have engaged in the same practices that the *Mayer* court found to violate Due Process rights – reducing hours with no justification. The extensive nature of this pattern was documented in a report by Medicaid Matters NY in 2016, "*Mis-Managed Care: Fair Hearing Decisions on Medicaid Home Care Reductions by Managed Long Term Care Plans.*"[7] A lawsuit brought at the same time challenging the pattern of reductions resulted in the Commissioner issuing State DDH MLTC Policy 16.06,[8] which specifically incorporated the same protections against arbitrary reductions that were established in 1996 under *Mayer*. The DOH policy specifically barred plans from using "mistake" in a previous authorization as a pretext for an arbitrary reduction

Since the *Mayer* protections, state regulations and MLTC Policy 16.06 that the Governor now seeks to repeal, are founded on the due process clause of the Fourteenth Amendment, any attempt to repeal

[7] Report available at http://medicaidmattersny.org/cms/wp-content/uploads/2016/08/Managed-Long-Term-Care-Fair-Hearing-Monitoring-Project-2016-07-14-Final.pdf.

[8] Policy available at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policy/16-06.htm. See also NY Times story about MLTC cuts, Nina Bernstein, *Lives Upended by Disputed Cuts in Home-Health Care for Disabled Patients*, 7/21/16, available at http://www.nytimes.com/2016/07/21/nyregion/insurance-groups-in-new-york-improperly-cut-home-care-hours.html.

them would be unconstitutional, and will likely invite more litigation to protect the constitutional rights of managed care members.

7. OPPOSE carve-out of transportation from MLTC services without procedures and oversight to ensure continuity of services in transition from MLTC coordination, and continued care coordination responsibilities of MLTC. (Part A, Sec. 1)

We have concerns about the proposal to take transportation off the benefit package of MLTC plans, unless provisions are added to ensure that the state's transportation vendors have the ability to provide transportation to MLTC enrollees. Unlike mainstream managed care members, which these vendors now serve, all MLTC enrollees by definition need assistance with everyday activities such as walking, and most cannot take public transportation for medical care. This change thus has the potential to disrupt care. Stringent quality measures must be required and adopted – now the law only requires them "if appropriate." NY Soc. Serv. L. § 365-h(4).

MLTC plans should continue to have responsibility for coordinating and arranging transportation services, even if they are no longer contracting with and paying the transportation vendors. While MLTC plans are charged with coordinating services they do not provide as well as services in the benefit package, we do not see this happening. Medicare home health services, for example, should be coordinated by MLTC plans, but in our experience plans are not aware when Medicare visiting nurse, in-home physical or occupational therapy, and home health care services terminate, so do not take steps to assess whether the consumer needs continuation of these services through Medicaid.. There is danger that coordination of transportation services will also be disrupted if the plans fail to coordinate them.

4. NYLAG ASKS THE LEGISLATURE TO SUPPORT:

a. Codification of the Affordable Care Act and establishment of the NYS of Health Exchange

We applaud the Governor's proposal to incorporate the Affordable Care Act and the NYS of Health Exchange in state law. This is a critical step to ensure that New Yorkers continue to benefit from the ACA protections, even if the ACA is repealed.

b. Funding of $1.1 billion to fully support the direct cost of minimum wage increases for health and home care workers, and ensure that these funds are actually used for worker wages. Funding is also needed to pay overtime when needed for continuity of care.

NYLAG has supported the recent increases in the minimum wage, which have been especially important to maintain the home care work force. The proposed funding is critical, as otherwise the minimum wage is an unfunded mandate that will not lift wages for health and home care workers working for Medicaid-funded providers. However, the legislation needs to be strengthened to increase accountability of managed care plans and home care agencies to ensure that the increased funding is used for increasing worker wages. We are also concerned that the $1.1 billion is not sufficient to meet the increasing demand.

Also, additional funding should be earmarked to pay overtime for home care aides, required under recent changes in federal labor law when aides work more than 40 hours/week. While we understand that authorizations to work overtime must be limited to limit costs, overtime is sometimes necessary for continuity of care, such as for a consumer who has dementia who has 12 hours/day of personal care. Two aides could staff her schedule, one working 4 days (48 hours/week), and one working 3 days (36 hours/week). One aide would be entitled to 8 hours overtime. Otherwise, 3 aides must staff the case, which is disruptive and confusing for the consumer. **There should be a procedure for a consumer to request a schedule that requires some overtime.**

c. Funding for the Managed Care Consumer Assistance Program, the state's community-based consumer assistance program for people with Medicare – and increase funding this year because of increased need.

NYLAG supports funding for the Managed Care Consumer Assistance Program, the state's community-based consumer assistance program for people with Medicare. We would like to thank Governor Cuomo for including level funding for the Managed Care Consumer Assistance Program (MCCAP) in his 2019-2020 budget proposal. MCCAP is a statewide program that provides essential assistance to low-income seniors and people with disabilities in accessing health services and reducing their Medicare costs. NYLAG has been a member of the MCCAP network of community-based organizations since the program's inception. Along with the other members of the MCCAP, NYLAG collaborates with the New York State Office for the Aging (NYSOFA) to take referrals of complicated cases and resolve complex Medicare and Medicaid issues for dual eligible.

NYLAG requests that the Legislature increase funding for MCCAP in 2019-2020 to the amount of $2,767,000, an increase of $1,000,000. We are pleased that the Governor's 2019-2020 Executive Budget includes funding for MCCAP at last year's level. However, several programs—New York State of Health (NYSoH), MLTC, and Dual Eligible Special Needs Plans (D-SNP)—have added to the complexity of the healthcare landscape for people with Medicare and those dually eligible for Medicare and Medicaid. Thousands of New York residents will need MCCAP agencies to continue serving as trusted on-the-ground resources explaining how such changes affect their Medicare prescription drug and health coverage, and access to healthcare providers.

As a greater number of residents become Medicare eligible MCCAP services are needed more than ever to help people enroll into valuable cost-saving federal benefits such as the Medicare Savings Program (MSP) and Extra Help. Enrollment for New York Medicare beneficiaries in the MSP is far under the national average. By providing $1 million in additional MCCAP funding, a new initiative could be started that is dedicated to reaching 25,000 more people with Medicare to educate them about the MSP and helping a minimum of 2,000 low-income New Yorkers enroll in MSP and Extra Help benefits. For an investment of $1 million, the state could save elderly and disabled New Yorkers, many of whom live in poverty and on fixed incomes, over $10 million in out-of-pocket expenses each year.

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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