Selfhelp

Submitted
Not Speaking

Testimony of Selfhelp Community Services, Inc.
Evelyn Frank Legal Resources Program

on

THE 2012-2013 EXECUTIVE BUDGET

TOPIC: HEALTH/MEDICAID/EPIC

Submitted to:

The Senate Finance Committee
and
The Assembly Committee on Ways and Means

Submitted by

Valerie Bogart, Esq.
Director, Evelyn Frank Legal Resources Program
Selfhelp Community Services, Inc
520 Eighth Avenue, 5th fl.
New York, NY 10018
Direct Dial 212.971.7693
Vbogart@selfhelp.net
Fax 212.947.8737
http://selfhelp.net

February 8, 2012

Selfhelp Community Services, Inc. appreciates the opportunity to submit testimony for this hearing on funding for critical Health and Medicaid services in the 2012-2013 Executive Budget.

Selfhelp Community Services has been caring for New York City's most vulnerable and dependent populations since it was founded in 1936. Today, Selfhelp serves more than 20,000 individuals each year, with a strong emphasis on programs that enable poor and underserved elderly to remain in their homes and active in their communities. Its mission:

Selfhelp is a not-for-profit organization dedicated to maintaining the independence and dignity of seniors and at-risk populations through a spectrum of housing, home health care, and social services and will lead in applying new methods and technologies to address changing needs of its community. Selfhelp will continue to serve as the "last surviving relative" to its historic constituency, victims of Nazi persecution.

Selfhelp's Evelyn Frank Legal Resources Program (EFLRP) is a consumer advocate for elderly and marginalized New Yorkers from diverse ethnic backgrounds, who, because of age or disability, need access to subsidized health care, prescription drug, and long-term care services. EFLRP provides direct legal services to over 800 seniors each year, and technical assistance to another 800 social workers and legal advocates who depend on our expertise with Medicaid, Medicare and other programs. As the 2011 cap on CHHA reimbursement was implemented, and pressure to cut Medicaid personal care services has increased, the number of calls to our helpline and requests for representation has increased steadily. We serve on the steering committees of coalitions raising beneficiaries' concerns the Statewide Consumer Coalition on Medicare Part D, and were appointed as consumer representative on the Fair Hearing Task Force of the MRT Managed Long Term Care Subcommittee.

Selfhelp's other services for elderly New Yorkers are provided at its 23 community-based sites in New York, Kings, Queens, Bronx, and Nassau Counties. Selfhelp is the largest provider of services to Nazi victims in the United States, serving over 5,200 Nazi victims each year. Selfhelp operates six senior housing complexes that house more than 1,000 residents and offer a wide continuum of on-site services; four Naturally Occurring Retirement Community (NORC) programs; three case management programs; five senior centers; home health care, skilled nursing, chore assistance, housekeeping, and emergency home care; Client Centered Technology Programs; a Social Adult Day Services Program; three Court-Appointed Guardianship Programs; Daily Money Management to help frail elderly; Emergency Cash Assistance; and, Selfhelp Senior Source (a fee-for-service geriatric care management program).

Selfhelp recognizes the gravity of the fiscal crisis facing our state and we greatly appreciate the commitment on the part of the Governor and the Legislature to maintain, and where possible to increase, access to both health insurance and health care services. We submit this testimony to alert you to several proposals raised through the Medicaid Redesign Team (MRT) process that we support because they remove barriers and increase access to health care. We are highlighting our concerns with proposals in the Governor's amended budget that diminish access to health care coverage, long-term care and services.

Improving Access to Health Care Services

We applaud the Governor for including the following proposals, which show a commitment to the removal of several important barriers to accessing Medicaid and health care services for low-income New Yorkers:

- **SafeRx** -- Accessible Prescription Labels Proposal that will reduce health disparities and improve access to prescription drugs for people of color, immigrants, seniors, and people with disabilities, among others, by requiring language access for people with Limited English Proficiency at pharmacies. (sec. 10-18)
- **Facilitated enrollment services for the elderly and disabled** – This proposal from the Medicaid Redesign Team's Work Group on Streamlining and State and Local Responsibilities is a significant step forward in ameliorating the long-standing exclusion of aged and disabled applicants from New York's facilitated enrollment program, making vital counseling and enrollment assistance available for aging and disabled person. While health reform will streamline and simplify eligibility for younger, healthy populations, Medicaid eligibility is not being simplified for seniors and people with disabilities – if anything, there is more need for counseling as new choices emerge with selecting "managed long term care" plans and new programs for dual eligibles.
- **New York Health Benefit Exchange Act** – new Article 10-E in the Public Authorities Law is necessary for New York to implement the Affordable Care Act in the most efficient and effective way for New York
- Restoration of **Podiatry visits** for adults with diabetes mellitus
- **Nutritional Supplements like "Ensure"** – while we support restoration of these vital supplements for people with HIV/AIDs, we oppose the omission of others who need these supplements because of other chronic conditions – see more below.

Concerns about Detrimental Changes Impacting Seniors and People with Disabilities

We wish to highlight three central concerns:

(I) elimination of "spousal refusal,"

(II) The need to restore access to critical medical services, including:

  a. the need for an override to the 20-visit annual cap for physical therapy and other rehabilitation services where medically necessary;

  b. restoration of Ensure and other nutritional supplements for all those with chronic conditions,

  c. the virtual elimination of the "bed-hold" for nursing home residents;,

(III) Restoration of coverage in EPIC program, and

(IV) Consumer protections needed in implementation of last year's mandatory managed long term care program.

(I) REJECT PROPOSAL TO ELIMINATE "SPOUSAL REFUSAL" -- THAT WILL MAKE DIVORCE or NURSING HOME CARE THE ONLY OPTION FOR MARRIED COUPLES

The repeal of "Spousal Refusal" for couples seeking to avoid institutionalization of one spouse will lead to increased institutionalization (at higher Medicaid costs) and encourage divorce.[1] Though the proponents of this change have in mind the so-called "millionaires on Medicaid," the reality is that, according to a spokesperson for the NYC Human Resources Administration, "...in most cases the spouse does not have the financial means to allow any significant contribution."[2] HRA and other local districts have been successful in recouping millions of dollars in Medicaid expenditures in the relatively few cases where the spouse has resources. Id.

New York's spousal refusal provision eliminates the huge inequity that allows the "community spouse" of an institutionalized spouse to keep enough of the couple's combined income and resources to realistically meet his living expenses -- up to $2841 in monthly income, and at least $74,820 and up to $109,560 in assets. Yet -- the same spouse who seeks to obtain Medicaid home care to care for his wife at home must impoverish himself so that the couple's combined assets are $20,850, and combined income is $1179/month. These levels are simply not enough to live on in New York City -- or anywhere else in the state. This creates a huge pressure on the "well spouse" to institutionalize the disabled spouse, as a purely financial decision. The only alternative is divorce.

Every week our program counsels couples who are relieved to be able to obtain vital home care for the spouse with a disability, and still retain enough income and assets to pay their living expenses. These are not millionaires. These are low income people with meager savings, if any, struggling to make ends meet. We can assure them that New York City, as well as some other counties, have had the reasonable longstanding practice of using the spousal impoverishment standards for nursing home care as a guide in prioritizing which "refusing spouses" to pursue for support. Since these couples have income and assets well within these limits, we can assure them that NYC will not sue them. Setting this as a statewide standard would lift the burden from the State or counties to commence legal proceedings for support, limiting such claims to those individuals with substantial means beyond the impoverishment limits.

Children with severe disabilities who need Medicaid should be eligible under the same standards -- if their parents fail or refuse to contribute assets or income that are within the "spousal impoverishment" limits, children should be eligible without counting the parents' income and assets.

A hardship exception must be retained to ensure Medicaid coverage for spouses and children who are victims of **spousal or parental abuse or neglect.**

Additionally, the LONG-TERM CARE FINANCING DEMONSTRATION PROGRAM ("THE COMPACT") ENACTED IN 2010 PROVIDES AN INNOVATIVE SOLUTION TO LIMIT MEDICAID EXPENDITURES – GIVE IT A CHANCE. There are better ways for the government to keep Medicaid costs in check than removal of spousal refusal. The long-term care financing demonstration program, known as "the Compact", was adopted in the 2010

---

[1] Federal law guarantees the right of spousal refusal for spouses of nursing home residents (42 U.S.C. §1396r-5(c)(3)).

[2] *"Full Wallets, but Using Health Program for Poor,"* New York Times, Dec. 10, 2010, quoting Carmen Boon.

budget, but has not yet been implemented. (Social Services Law §366-i) The Compact establishes a joint public/private venture where the cost of health care is shared equally by individuals and the government. Individuals pledge to privately pay for their care first, with Medicaid only paying after the individuals have spent their pledge amount. Therefore, individuals will only become eligible for Medicaid after they spend their pledge amount on their own care. As the number of individuals seeking Medicaid has grown, the Compact provides a means to increase individual contributions for care without requiring total impoverishment.

Changes Cannot be Implemented Now without Violating the Maintenance of Effort Requirements of the Affordable Care Act –

This change would violate the ACA requirement "to maintain Medicaid eligibility standards, methods and procedures" in effect on March 23, 2010 until CMS finds the State's insurance exchange is fully operational, estimated to be January 1, 2014. An exception is made if the State certifies that it has a budget deficit. Even then, changes may be made only for those not eligible on the basis of disability (or pregnancy) and for those whose income is above 133% of the Federal Poverty Level.[3] *NYS could not eliminate spousal refusal until around January 2014, for:*

- 737,924 Individuals with disabilities under age 65 – out of 1,011,239 aged, blind or disabled Medicaid recipients in NYS in Oct. 2010[4]
- People age 65+ applying for or receiving Medicaid whose income is less than 133% FPL - $1207/month (single) $1630/mo (couple). Local districts would have to determine which of the 273,315 Aged Medicaid recipients in NYS (see n 1) who are not receiving SSI have incomes above 133% FPL. (who are spending down excess income to the NYS income level, which is about 84% FPL ($767/mo – single, $1117 - couple). Recent reports show that the number whose income exceeds 133% FPL may be just a fraction of the 273,315 figure.[5]
- Identifying those seniors with incomes above 133 % FPL (and giving them notice and the right to appeal this determination), and applying a different set of rules to this group, would impose a huge bureaucratic burden on local districts.

---

[3] CMS Letter to State Medicaid Directors, Maintenance of Effort, 2/25/11, http://www.cms.gov/smdl/downloads/SMD11001.pdf

[4] NYS Dept of Health, Monthly Medicaid Enrollee Reports, Number of Medicaid Enrollees by Category of Eligibility by Social Service District, Oct. 2010 http://www.health.state.ny.us/nysdoh/medstat/el2010/mo_10_el.htm

[5] A New York Health Foundation study found the majority of NYC beneficiaries have "excess incomes" or "spend-downs' under $200/month, with the bulk of the remainder under $400/month – and lower outside of NYC. By inference, the income levels of the vast majority of beneficiaries are under 133% FPL. Manatt Health Solutions, *Streamlining New York's Excess Income Program*, New York Health Foundation (2009). http://www.nyshealthfoundation.org/userfiles/file/EIP%20Report%205_2009_v4.pdf at p. 22.

(II) RESTORE ACCESS TO CRITICAL MEDICAL SERVICES

a) **Allow Physician to Prescribe Additional Physical Therapy, Occupational Therapy, Speech Therapy and Speech-Language Pathology therapies when 20 annual visits not enough.** Last year, the budget limited these therapies to 20 **visits in a 12 month period**—except for individuals with developmental disabilities, Traumatic Brain Injuries, and children. *These limitations make it more difficult for individuals with other disabilities, including many seniors, to maintain or improve their functioning and result in deterioration and the need for higher levels of (and more expensive) care. Even if a series of 20 visits was sufficient for one injury or post-surgery rehabilitation what happens if an suffers a second or third medical crisis needing another round of treatment? A process for overriding the cap where medically necessary must be enacted. New York already has a working system for such overrides in its "utilization threshold" program that limits lab tests, prescriptions, and physician's visits subject to an override.*

b) **Expand the Governor's proposal to restore Medicaid coverage of "Ensure" to all people who need nutritional supplements because of chronic medical conditions, subject to standards to be set by the Commissioner of Health.** Last year, all coverage for these vital nutritional supplements was eliminated, except for those who are tube-fed. The Governor would lift last year's harsh ban on coverage only for people with HIV and AIDS. While this is some progress, the Governor's proposal will still deny vital nutrition for many seniors and people with disabilities with Alzheimer's disease, cancer, advanced multiple sclerosis, Parkinson's disease, and other conditions. The law should authorize DOH to set standards to provide these supplements to all those who, because of chronic medical conditions, are unable to chew or swallow regular food, who rely on these supplements for adequate nutrition. Standards for determining when these supplements are necessary can still save Medicaid dollars.

c) **Maintain "Bedhold" Payments for People whose Home is a Nursing Home** -- The Governor's budget essentially repeals the right of a nursing home resident to return to his or her own bed if she is temporarily hospitalized, or leaves the nursing home for a therapeutic leave, such as a stay with family for a holiday. Last year's restriction on "bed hold" payments was rejected by the federal Medicare and Medicaid agency, CMS. We urge restoring the previous rule in effect for many years, which restricted bedhold payments to nursing homes with vacancy rates above a certain threshold. This rule protected Medicaid dollars by ensuring that payment was made only if truly necessary to hold the bed. Ending these payments will mean that someone who may have lived in a nursing home for years, with established relationships and routines, is at risk of being forced to move to a different nursing home after a traumatic hospital stay. For tens of thousands of seniors and people with disabilities, a nursing home is their home. The right to return home after a temporary medical or therapeutic leave must be maintained. Other states that may have no bedhold payments should not be cited as a precedent, as the vacancy rate in these states is likely to be significantly higher than the threshold used in New York.

(III) RESTORE CUTS IN THE EPIC PROGRAM

Seniors are already facing severe hardship from last year's cuts in the EPIC program. The cuts especially affect people whose income is just over the limits for the federal Part D subsidy called "Extra Help" – 150% of the Federal Poverty Line. For a single person, this limit is $16,755 a year or monthly income of $1,396. For couples the limit is $22,695/year or $1,891/month. For people above this income level, the only help EPIC now provides is Part D premium assistance (if income is less than $23,000/singles or $29,000/couples) and coverage during the "doughnut hole."

But Part D coverage requires high out-of-pocket costs year-round, not just during the "doughnut hole." For example, co-insurance for a Tier 4 drug in the popular AARP MedicareRx Preferred plan, coinsurance is $42.00 for Tier 3 drugs, $91.00 for Tier 4 drugs, and 33% of the full drug cost for Tier 5 drugs. Our client takes micardis for high blood pressure – a Tier 4 drug. His copay for this drug alone is $91/month, on top of his other medications. With EPIC, the copayment was $20.

We ask for restoration of EPIC's coverage during the Part D annual deductible period and EPIC wrap-around coverage of Part D coinsurance during the initial coverage period.

Alternatively – Shift EPIC members to the Medicare Savings Program by increasing the Income Limits -- Saving State Funds and Protecting Key Subsidies for Seniors

The legislature has an opportunity to maintain vital access to prescription medications for seniors and to expand access for individual with disabilities while maximizing federal matching funds. Currently EPIC is funded with state-only dollars and access to Part D subsidies is limited to individuals who meet the currently eligibility levels for Extra Help or for New York's *Medicare Savings Program* (MSP) eligibility levels, the highest being 135% of the federal poverty level.

New York should adopt steps taken by Washington, DC, Connecticut and Maine to increase the income levels at which seniors and individuals with disabilities qualify for MSPs. Individuals eligible for MSPs are automatically eligible for Extra Help, the Part D subsidy funded by the federal government. This subsidy provides cost-sharing protection by eliminating annual deductibles, monthly premiums and the donut hole. It also provides a federal subsidy to Part D co-pays so that the beneficiary pays only $2.30 for generics and $6.30 for brand name prescriptions. These limits are less than most EPIC enrollees currently pay. In addition to the increased cost-sharing protection, MSPs pay for Part B premiums so seniors would have an additional $99.90 in income each month. Maine increased its MSP income level to equal the income level for its own EPIC-type program, so that the federal "Extra Help" subsidy now took over much of the drug costs formerly paid by Maine's EPIC-type program. If New York increased the MSP income limit to 320% of the FPL, all EPIC members would be enrolled into Extra Help.

Savings would be achieved by shifting the cost of drugs now paid by EPIC for Part D premiums and the Part D "doughnut hole" to the federal Part D plans, and by reducing the cost of administering the EPIC program. Cost incurred by expanding the eligibility levels for the MSPs is shared with the federal government, so the State share is half the cost of paying the monthly Part B premium ($99.90) for SLIMB and QMB, and for a third MSP -- QI-1 -- the federal government pays the ENTIRE cost with no state share. The net gain for the State would be substantial.

(IV) Protect Consumer Rights in Implementation of Managed Long Term Care

Last year's budget mandated that all Medicaid recipients needing community-based long term care enroll in a managed long term care plan. The State is still negotiating approval of the 1115 waiver needed to implement this change, which was supposed to go into effect April 2012, first in New York City, then rolling out to Long Island and eventually upstate. When approved, over 100,000 seniors and people with disabilities now receiving stable home care services through the personal care program, certified home health agencies, or long term home health care (Lombardi) programs, will be required to select a managed long term care plan (MLTC) or be assigned to one. These plans will have the power to reduce or even terminate home care services that have kept the senior or person with a disability safely in his or her home for many years.

Consumer protections are needed to prevent unnecessary institutionalization – with potential violations of the Olmstead decision and the Americans with Disabilities Act -- and to maintain health and safety at home.

- **Reporting, transparency, and tracking** -- Plans should be required to report data reflecting changes in the level, type and amount of services new enrollees receive compared to the services they previously received in personal care, CHHA, or long term home health care programs, and changes for members receive over time. The State must track and investigate plans that are reducing services or using nursing home services in lieu of home care more frequently than other plans, or that are authorizing fewer hours of service than the norm.
    - Data measures from cost and quality reports should be required in the same units of service (hours v. visits) so that they can more easily be tracked and compared.
    - The Department should summarize the data in a form that makes plan comparisons possible for consumers and their advocates, and then publicize the data on the Department's website.
    - The Department should summarize the data and reports they receive for plans in quarterly presentations to the Legislature and the Medicaid Managed Care Advisory Review Panel (MMCARP), which was charged with overseeing the implementation of Managed Long Term Care in last year's budget.
    - Rates of voluntary enrollment and auto-assignment for each plan should be monitored and reported to the Legislature and MMCARP on a quarterly basis

- **Services pending appeal – Longstanding existing hearing rights must be maintained for notices and fair hearings, including the fundamental right to "aid continuing.'** If the recipient requests a fair hearing within a specified time, the plan must continue to provide services at the previous level until the state hearing agency renders its decision, regardless of whether authorization period for the services that the recipient had been receiving has expired. *Under the rules the State has proposed, the plan may wait out an authorization period, and then terminate services altogether – or drastically reduce hours. While the State would require the plan to give notice, with the right to request a hearing, the plan will not have to give these vital "aid continuing" benefits pending the hearing. The consumer could*

be at grave risk of harm during this period, with no services whatsoever. We believe the lack of services pending an appeal would violate constitutional due process requirements.

- **Standards** – The State is now testing a Uniform Assessment Tool that is projected to be ready for use in October 2012. Even with this tool, plans will have unfettered discretion to determine how much services to authorize – there are no uniform standards. The managed care plans should be required to use the assessment and authorization, timelines, standards, and policies consistent with state plan personal care services, as these standards have developed through regulation and departmental guidance. Over decades, the Department of Health as developed guidance that ensures the provision of personal care services, for example, to people with dementia who need verbal cueing in order to safely perform basic activities of daily living – this guidance put a stop to local district practices of denying personal care to people with cognitive impairments such as Alzheimer's disease.
- **Ombudsprogram** -- The State should require the commissioner to designate an ombudsperson to advocate for persons enrolled in managed long term care programs. The ombudsperson shall advocate for recipients enrolled in managed long term care programs through the state appeal process and assist enrollees in accessing necessary medical services directly or by referral to appropriate services. At the time of enrollment in a managed long term care program, the local agency or enrollment broker shall inform recipients about the ombudsperson program.