New York State Bar Association
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Memorandum Urging Approval

ELDER LAW AND SPECIAL NEEDS SECTION

Elder #5-GOV

September 16, 2019

S. 5485-A — By: Senator Rivera
A. 7578-A — By: M. of A. Gottfried
Senate Committee: Health
Assembly Committee: Ways and Means

THE ELDER LAW AND SPECIAL NEEDS SECTION SUPPORTS THIS LEGISLATION AND URGES ITS APPROVAL

The Elder Law and Special Needs Section of the New York State Bar Association strongly supports A07578 (Gottfried)/ S05485(Rivera).

This bill would improve two burdensome and error-prone Medicaid procedures which now cause seniors and people with disabilities to lose Medicaid, Medicare Savings Programs, and/or home care coverage, despite being eligible. First, by automating the annual Medicaid "renewal" process, which now is burdensome and error-prone, it will prevent the erroneous termination of Medicaid eligibility for several vulnerable populations. When Medicaid is cut off because of a glitch in the renewal process, the individual is automatically disenrolled from their Managed Long Term Care (MLTC) plan, resulting in the loss of life-saving home care benefits.

Second, the bill would automatically enroll consumers into a MLTC plan after they have been approved for Medicaid and for MLTC enrollment and after they have been given the opportunity to choose their own plan but have been unable to do so. Currently, those who cannot manage to navigate the many hurdles to timely enroll in an MLTC plan lose their eligibility for MLTC, and they must begin the entire process again. The delay in accessing home care services places them at risk of harm. This bill would align the MLTC program with mainstream Medicaid managed care, in which individuals approved for Medicaid have always been auto-enrolled in a plan after a choice period.

1. Automatic Recertifications for MLTC, Medicare Savings Program & Others Aged, Blind and Disabled:

Over the last fifteen years, advances in technology have enabled the state and local Medicaid programs to verify many types of income and financial resources of applicants and recipients electronically, without requiring documentation from the applicant or recipient. With these advances, applicants and recipients could "attest" to the amount of their income or resources, without the burden of submitting documentation. See NYS DOH 04 ADM-06 - *Attestation of Resources*; 05/OMM-INF-2, 11 OHIP/ADM-9 - *Automated Medicaid Renewal for Individuals with Fixed Incomes in the Aged, Blind and Disabled Category*. Federal law at 42 U.S.C. § 1396w requires states to implement a program for verifying assets for purposes of determining and re-determining Medicaid eligibility for aged (age 65 or over), certified blind and certified disabled applicants and recipients. NYS DOH has done this through 2017 Administrative Directive 17

OHIP/ADM-02 *Asset Verification System*, which is implemented statewide except not fully in New York City.

Despite these advances in technology, and despite the fact that most seniors and people with disabilities who receive Medicaid have fixed incomes and assets, New York has continued to require enrollees who are Aged, Blind or Disabled to undergo a burdensome and error-prone mail renewal process annually to prove they are still eligible for Medicaid or the Medicare Savings Program. The renewal packages are mailed to recipients who, due to disability, age, and/or language, are unable to understand and respond on a timely basis. Stories are legion of consumers who never receive these mailings, or who submitted the required response, only to have Medicaid discontinued for an alleged "failure to recertify."

The Medicaid mail renewal process is an unfortunate example of the old "churning" process in welfare systems. Recipients are cut off Medicaid not because they are not eligible, but because they fall victim to the bureaucratic barriers of an archaic mail renewal system. If the local district fails to process the renewal in time, or finds the recipient did not sufficiently document eligibility, the district should then send a Notice of Intent to Discontinue Medicaid, with the right to request a hearing and Aid Continuing. However, the consumer often does not receive the discontinuance notice at all, or may not have the wherewithal to request a fair hearing in the short 10 days from the date of the discontinuance Notice to obtain "Aid Continuing." Navigating the hearing process is difficult, and most consumers do not find their way to a legal services advocate.

The consequences of being "churned" off of Medicaid or Medicare Savings Program eligibility are severe. If a Fair Hearing isn't requested in time for Aid Continuing, the consumer is automatically *disenrolled* from an MLTC plan – leading to cut-off of home care services. Even if they manage to request a fair hearing quickly, an Aid Continuing directive does not automatically re-enroll them in their MLTC plan – this requires extensive advocacy. Even the constitutional due process protection of Aid Continuing, then, is not enough to ensure continuity of vital home care services in the complex MLTC system. Although some MLTC plans continue services after discontinuance with the assumption that the case will be fixed, in many cases the plan does not actually help their member to recertify during that time and ultimately stop services without notice.

Similarly, when an individual is "churned" off of the Medicare Savings Program, if they do not manage to get Aid Continuing with a fair hearing request, their Social Security check is reduced by $135.50/month – the cost of the Medicare Part B premium. For someone whose income is under $1406/month, this reduction can be catastrophic.
This bill seeks to stop the cycle of "churning" eligible people off of Medicaid by automating the Medicaid recertification process for these four groups:

1. Managed Long Term Care (MLTC) enrollees,
2. Mainstream managed care members receiving personal care or consumer-directed personal assistance (CDPAP) services,
3. Medicaid enrollees in the Aged, Blind, and Disabled Category without excess income,
4. and Medicare Savings Program (MSP recipients).

According to a 2011 Administrative Directive, 11 OHIP/ADM-9 - *Automated Medicaid Renewal for Individuals with Fixed Incomes in the Aged, Blind and Disabled Category*, the latter two groups should already receive automatic renewals, but this bill codifies that requirement in statute.

The annual recertification process for MLTC enrollees is a waste of resources for plans, local districts, the State Department of Health, enrollees, and their families. The majority of MLTC enrollees are on fixed incomes, which increases only incrementally through cost of living increases. Each year they must undergo a recertification process which is so prone to errors that seniors and people with disabilities routinely have Medicaid cut off erroneously.

Allowing deemed resource eligibility and attestation for these groups would not put the State at risk of reauthorizing Medicaid for people who are ineligible. Attestation of resources is already used in many parts of Medicaid, with no reported downside. The Medicaid program already conducts investigations for potential ineligibility and would continue to do so. This would not change enrollees' obligation to report changes in income or resources and would not change excess income liability to the plans.

2. Auto-Enrollment of Eligible Medicaid Recipients Into MLTC Plans

People who have successfully applied for Medicaid in order to enroll in a MLTC plan face many hurdles and delays before they can actually enroll in a plan.

First, under the Special Terms & Conditions of the 1115 waiver authorizing the MLTC program,[i] they must first schedule an in-home assessment by a nurse from the Conflict Free Eligibility and Enrollment Center (CFEEC), which the State has contracted with Maximus to run through NY Medicaid Choice. It can take several weeks to schedule that half-day assessment, the purpose of which is to ensure that the individual requires community-based long term care services for more than one hundred and twenty days. Over 90% of people assessed are determined eligible. Not until that assessment is completed may the Medicaid recipient schedule in-home assessments with prospective MLTC plans. At that assessment an MLTC plan nurse assesses the individual, and if they agree, processes the enrollment, which is effective either the 1st of the following month, or, if it is already too late in the month (after the 18th), effective the 1st of the month after the following month. It can take an MLTC plan several weeks to schedule those assessment visits. Meanwhile, the clock is ticking as the CFEEC determination is only good for 75 days – if the individual is not enrolled by then, the CFEEC expires and must be redone, requiring scheduling a new visit a few weeks down the road. See DOH MLTC Policy 16.08: *Conflict Free Evaluation and Enrollment Center (CFEEC) Update to Expiration of Evaluations (available at* https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policy/16-08.htm*)*.

Second, MLTC plans often discourage enrollment of members who may be perceived as having high needs, since the plan wants to avoid providing high-cost care with the fixed capitation rate. For example, an individual who is bedbound, living alone, may need 24-hour/day care. The plan representative, however, might say they would authorize fewer than eight hours/day. The consumer is then incentivized to shop around for another plan that might approve the number of hours needed. Plans also have been known to say that the individual cannot be safely cared for in the community, and requires nursing home placement, even though the CFEEC has found them eligible for community-based long term care services; this is another common pretext for avoiding a high-need consumer. With the closing of Independence Care Systems (ICS) and Guildnet MLTC plans, which had reputations for providing adequate care to higher needs members, there are fewer options for the consumer.

Third, MLTC plans will be even less incentivized to authorize high hours of care when needed if and when CMS approves the carve-out of permanent nursing home care from the MLTC package. People in nursing homes, though determined to be eligible for community based services through a CFEEC, will not find an MLTC plan willing to provide the services they need to return home to

the community. People in the community with high needs will be avoided by the MLTC plans, as they are now, and will end up in nursing homes.

In contrast, consumers who do not have Medicare have long been auto-assigned to managed care plans if they do not select a plan within 30 days of being approved for Medicaid. Soc. Serv. L. §364-j, subd. 4(f). The law provides that this auto-assignment may be on a weighted basis, "…taking into account capacity and geographic accessibility. The commissioner may … assign participants to a managed care provider taking into account quality performance criteria and cost. Provided however, cost criteria shall not be of greater value than quality criteria in assigning participants." Id.

This bill would establish an auto-assignment protocol for MLTC similar to that used in mainstream managed care be required. Auto-assignment would prevent delays in enrollment and curtail the cherry-picking that plans engage in to avoid high-need consumers. Auto-assignment would ensure that a consumer who has been screened by the CFEEC enrolls in an MLTC plan before the CFEEC expires after 75 days. The bill additionally provides that the CFEEC would be deemed to be in effect – and does not expire – if the auto-assignment is not completed by the 75th day after the CFEEC determination.

For the reasons stated above, the NYSBA's Elder Law and Special Needs Section supports this legislation and urges its approval by the Governor.

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[i] CMS Special Terms and Conditions, dated 1/19/17 available here, https://www.health.ny.gov/health_care/managed_care/appextension/docs/2017-01-19_renewal_stc.pdf ; see page 37.