

## THE 2016-2017 EXECUTIVE BUDGET – Medicaid Changes

### Summary

1. **Impoverishment Protections At Risk for Married Couples and Children with Chronic Illness:**
  - A. Preserve or expand Spousal Impoverishment resource protections where one spouse is in a Managed Long Term Care plan, waiver program, or a nursing home.
  - B. Preserve Spousal Refusal
2. **If MLTC is Restricted to Those Needing Nursing Home Level of Care**, ensure other obtain Personal Care from HRA CASA or other DSS and that MLTC's do not Discriminate against High Need Members.
3. **Preserve Medicaid and "QMB" Reimbursement Rates to Medicare Advantage Plan Providers**
4. **Remove Medicaid Physical, Occupational & Speech Therapy Visit Caps**

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1. **Preserve Protections that Prevent Impoverishment of Married Couples and Ensure Access to Health and Long Term Care for Vulnerable Spouses and Children (Part B, sections 3-4)**

The Governor's proposed 2016-2017 budget would make two changes that will impoverish married couples where one spouse needs Medicaid, and deny Medicaid for children with severe illness.

#### **A. PRESERVE OR EXPAND – RATHER THAN REDUCE – THE SPOUSAL IMPOVERISHMENT RESOURCE ALLOWANCE**

Congress enacted the federal "spousal impoverishment" protections in 1988 to prevent one spouse from becoming impoverished when the other spouse needs Medicaid to pay for nursing home care. The Affordable Care Act [ACA] expanded those protections to protect couples where one spouse is enrolled in a Managed Long Term Care plan.<sup>i</sup> This ACA provision at long last *potentially* removes the institutional bias that has long pervaded Medicaid long term care services – removing the financial incentive to institutionalize a spouse. The spousal protections provide a "well spouse" with some financial security, and can prevent her from needing to rely on Medicaid for her own medical or long term care.

States have an option of setting the resource allowance between a minimum floor of \$23,844 and a ceiling of \$119,220 of the couple's combined assets. The ceiling was originally \$60,000 when the federal law was enacted in 1988, and has gradually increased by a statutory consumer price index adjustment to the current \$119,220.<sup>ii</sup> New York elected the highest federally allowed resource allowance twenty years ago in 1995, when it was at \$74,820 with the consumer price index adjustment. **However, New York never increased it by the federal cost-of-living index, while in the last 20 years, the federal maximum resource allowance has increased to \$119,220.**

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

1. the resource allowance as set by the state between \$23,844 and \$119,220 – New York’s allowance has been \$74,820 since 1995- OR
2. one-half of the couple’s combined assets, up to \$119,220.

Thirteen states including Massachusetts and California set the resource allowance at the highest level permitted - \$119,220 as of 2015.<sup>iii</sup> If New York reduces the allowance as proposed, it will join 32 states with allowances at \$25,000 or under, despite its high cost of living. See n 3.

The Governor’s proposal will hurt couples with the *least* assets – between \$23,500 and \$150,000, while not affecting those with combined assets over \$150,000. Here are examples of the disparate impact of the Governor’s proposal on couples of more modest means:

- George and Martha have \$47,000 in life savings. Before, Martha could keep **all** of these savings when George enrolls in an MLTC plan or enters a nursing home. Under the Governor’s proposal, Martha could keep only **half** of their savings, or \$23,500.
- Brad and Angelina have \$238,000 in life savings. Before, Angelina could keep half of their combined savings -- \$119,220 – when Brad enrolls in an MLTC plan or enters a nursing home. This will not change under Governor’s proposal. She can still keep \$119,220.
- More examples:

Couple’s combined assets	Amount of Assets Community Spouse May Keep		
	If allowance raised to federal maximum	Under Current NY Law	Under Gov’s PROPOSED CHANGE
<b>\$30,000</b>	\$30,000	\$30,000	<b>\$23,500</b>
<b>\$47,000</b>	\$47,000	\$47,000	<b>\$23,500</b>
<b>\$75,000</b>	\$75,000	\$75,000	<b>\$37,500</b>
<b>\$119,220</b>	\$119,220	\$75,000	<b>\$59,610</b>
<b>\$150,000</b>	\$119,220	\$75,000	<b>\$75,000</b>
<b>\$238,000</b>	\$119,220	\$119,000	\$119,000
<b>\$350,000</b>	\$119,220	\$119,220	\$119,220

New York is well known to have one of the highest costs of living in the nation,<sup>iv</sup> which is why the legislature 20 years ago opted for the highest resource allowance permitted by federal law. Unfortunately, unlike other states, the state legislature did not enact a cost of living increase, even though the costs of living have skyrocketed. If anything, New York should join those 12 states to opt for the *highest* permitted allowance of \$119,220, to prevent eviction or homelessness, and prevent forcing spouses to resort to Medicaid because of depleted savings.

## B. REJECT THE PROPOSED ELIMINATION OF THE SPOUSAL AND PARENTAL REFUSAL.

The Governor's proposed 2016-2017 budget will deny Medicaid to low-income married seniors who need Medicaid to help with Medicare out-of-pocket costs or long-term care. Medicaid would be available ONLY if the parent lives apart from his sick child, or the "well" spouse lives apart from or divorces her ill spouse - or puts her spouse in a nursing home. NYLAG opposes the requirement that families split up in order to obtain Medicaid to these vulnerable groups. We question whether this cut will achieve the savings intended.

Since 2014, fewer married couples need to use spousal refusal where one spouse enrolls in a Managed Long Term Care (MLTC) plan in order to receive home care. This is because in 2014, "spousal impoverishment" protections first became available to married couples when one spouse is receiving MLTC services, as a result of the Affordable Care Act (ACA).<sup>v</sup> The extension of "spousal impoverishment" protections to married persons receiving MLTC or other "waiver" services is an important tool to prevent unnecessary institutionalization and poverty. It eliminates the longstanding bias that allowed married spouses of nursing home residents to retain enough income and assets to live without impoverishment, but required spouses of home care recipients to live at the sub-poverty regular Medicaid levels.

However, there are critical gaps in these protections that continue to make spousal refusal essential.

First, New York State, in violation of federal guidance,<sup>vi</sup> refuses to authorize the spousal impoverishment protections at the time the Medicaid application is filed and approved. Eligibility is first evaluated under regular income and asset rules *without* the spousal impoverishment allowances, so that the application is REJECTED if a couple had \$75,000 in assets (or \$23,500 if Governor's proposal is enacted). The spouse MUST use Spousal Refusal in order to get Medicaid approved and enroll in MLTC. Only after the application is accepted and the spouse enrolls in an MLTC plan can they request a "re-budgeting" using the spousal impoverishment protections.<sup>vii</sup> Then, many couples become fully eligible without Spousal refusal. The State's insistence that spousal protections are available only "post-eligibility" is a barrier to MLTC enrollment, unless the spouse can do a "spousal refusal" for the initial application.

Similarly, without spousal impoverishment income protections, the same couple must use spousal refusal in order for the spouse to have Medicaid approved. Otherwise, a couple with combined income of \$3,364 would be initially charged with an income "spend-down" of \$2,200/month. Spousal refusal is essential to get the application accepted, and to allow the "sick spouse" to enroll in an MLTC plan. Only after MLTC enrollment may the couple request re-budgeting with the spousal impoverishment protections – which will allow them to keep their income and assets without any spend-down and without needing spousal refusal from then on.

**EXAMPLE: Marie Z was only age 58 when she started showing signs of early Alzheimer's disease.** Her husband of nearly 40 years works full time. They had good health insurance through his employer – which costs the couple \$1800/month, but it does not cover long term care. One of their daughters quit her job to care for her, but with Marie's round-the-clock needs they needed formal 24-hour home care. NYLAG assisted her in filing a Medicaid application in March 2015, with her husband filing a Spousal Refusal. It took over seven months until Medicaid was approved in August 2015, in part because Mrs. Z was so young – under age 65 -- that she could only qualify by being determined officially "disabled," which takes extra time. Finally, in October 2015, Marie enrolled in an MLTC plan. Without spousal refusal, she would have had to be placed in a nursing home – removed from her husband of 40 years and her Bronx home.

**2. Proposal to Restrict MLTC to Those who would Otherwise Need a Nursing Home – affecting about 5 Percent of all new MLTC members. (Existing MLTC members would be “grandfathered in.” )**

A. If this means some people will now get home care through HRA CASA, like the old days, HRA and other Local Departments of Social Services must have the necessary resources to assess the need for and authorize services – do they still have enough nurses, case workers, and home attendant vendors to handle these cases? This is especially a problem outside of NYC.

B. Will this put more pressure on MLTCs to discriminate against high-need members? Since they won't be able to “spread the risk” and balance the cost of care with low need members? To guard against that, create incentives like a High Needs Community Rate Cell – a special rate for those needing 24-hour care, increase government Oversight, create Fair Wage Guarantees, and add other protections sufficient to reverse the existing incentives within the capitation for MCOs or MLTC plans to deny necessary services to enrollees with significant disabilities, or to push them into institutions or out of their plans.

**3. Do Not Cut Medicaid Reimbursement Rates to Medicare Advantage Plan Providers for Members in QMB or Medicaid**

We oppose the Executive Budget proposal to reduce Medicaid reimbursement to providers who treat individuals dually eligible for Medicare and Medicaid. The proposal would cap the amount Medicaid contributes towards a Medicare Advantage member's coinsurance or copay so that the total reimbursement the provider receives from both the Medicare Advantage plan and Medicaid is no higher than the total Medicaid would have paid for the service. This proposal will only exacerbate the challenges dually eligible individuals have finding providers willing to provide services to them. Under federal rules, QMBs may not be balance billed for Medicare or Medicare Advantage co-insurance or copays even by providers who do not accept Medicaid generally. Nevertheless, providers continue to balance bill QMBs, and when they learn that is impermissible, some simply refuse to continue to see QMB patients.

The consequences for dually eligible clients are real. Last year, the enacted budget reduced the Medicaid reimbursement for the Medicare Part B coinsurance for beneficiaries who have “Original Medicare” in the same manner that is now proposed for people in Medicare Advantage plans. As a direct result of that change in reimbursement, a chain pharmacy has informed a dually eligible consumer that it will have to start charging him the \$60-70 co-insurance for his Medicare Part B medications. Once the provider is educated on the prohibition on balance billing, the pharmacy may decide to simply no longer treat the consumer or fill his prescriptions.

**V. Remove Medicaid Physical, Occupational & Speech Therapy Visit Caps of 20 visits/year**

For the past four years, the 20 visit cap on physical, occupational, and speech therapy in the Medicaid program has resulted in denial after denial of medically necessary therapies. It has left Medicaid recipients with disabilities unable to maintain functionality they had, left victims of accidents in pain and without the means to regain full functionality, and left individuals without the ability to restore functioning after surgery. It is time for New York to reconsider the therapies cap, which has no medical necessity exception – not even for an entirely new accident or medical condition. Medicare places an annual dollar limit on the three therapies, but,

critically, provides for an exceptions process that allows coverage beyond the dollar limit where additional therapies are medically necessary.<sup>1</sup>

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<sup>i</sup> Section 2404 of the Patient Protection and Affordable Care Act (PPACA) amends 42 USC 1396r-5(h)(1)(A) to define “institutionalized spouse” effective Jan. 1, 2014 to include all “medically needy” spouses including those in various home care programs.

<sup>ii</sup> 42 U.S.C. § 1396r-5(f)(2) and 1396r-5(g).

<sup>iii</sup> As of 2015, 13 States used the federal maximum, and 29 use the federal minimum. Krause Financial Services, State-Specific Resources, available at <https://www.medicaidannuity.com/resources/state-resource/> (last visited 1/23/16). In 2010, 18 states used the maximum allowance and 25 used the minimum. “Access to Long-Term Services and Supports: A 50-State Survey of Medicaid Financial Eligibility Standards,” AARP, Public Policy Institute (2010), pp. 22-23. Available at [http://assets.aarp.org/rgcenter/ppi/ltc/i44-access-ltss\\_revised.pdf](http://assets.aarp.org/rgcenter/ppi/ltc/i44-access-ltss_revised.pdf) (last visited 1/23/16).

<sup>iv</sup> Mercer LLC rated New York City as having the highest cost of living of all U.S. cities in 2015, followed by Los Angeles and San Francisco. Mercer LLC, 2015 Cost of Living Rankings (June 2015), available at <https://info.mercer.com/Cost-of-Living-Ranking-2015.html> (last accessed Jan. 27, 2016 with free registration)

<sup>v</sup> See n. 1. The State DOH has implemented this through a series of directives – most recently [GIS 14 MA/025 - Spousal Impoverishment Budgeting with Post-Eligibility Rules Under the Affordable Care Act](#) (PDF), dated Nov. 3, 2014, rescinds an earlier [NYS DOH GIS 14 MA/015](#), issued August 5, 2014, and reinstates two even earlier directives, Pending further clarification from the federal CMS, "districts are to resume applying the policy provided in [GIS 12 MA/013](#), "Spousal Impoverishment Budgeting with Post-Eligibility Rules for Individuals Participating in a Home and Community-Based Waiver Program" and [NYS DOH GIS 13 MA/018](#), "Spousal Impoverishment and Transfer of Assets Rules for Certain Individuals Enrolled in Managed Long Term Care." These are all posted at [http://www.health.ny.gov/health\\_care/medicaid/publications/index.htm](http://www.health.ny.gov/health_care/medicaid/publications/index.htm).

<sup>vi</sup> 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).

<sup>vii</sup> 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](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](http://www.health.ny.gov/health_care/medicaid/publications/pub2014gis.htm) (last accessed Jan. 28, 2016).

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<sup>1</sup> 42 U.S.C. § 1396r-5l(g).