Contact: Maria Cilenti - Director of Legislative Affairs - mcilenti@nycbar.org - (212) 382-6655

TESTIMONY OF THE NEW YORK CITY BAR ASSOCIATION'S
LEGAL PROBLEMS OF THE AGING COMMITTEE
BY JUDITH D. GRIMALDI, CHAIR

MEDICAID TRANSITION TO CARE MANAGEMENT FOR LONG-TERM CARE

NEW YORK STATE ASSEMBLY COMMITTEE ON HEALTH
DECEMBER 7, 2012

The mission of the Legal Problems of the Aging Committee of the New York City Bar Association has for many years been devoted to enhancing the lives of New York's senior citizens, in general and, more particularly, to the most vulnerable of the elderly due to reduced financial means or severe disabilities. The Committee primarily fulfills this mission by focusing on substantive law that affects New York's elderly through educating the public and working with elected officials to comment on proposed legislation and/or suggest enhancements.

The Committee respectfully submits this testimony to express issues that we believe will most greatly affect the aging and disabled community with relation to the implementation of Managed Long Term Care (MLTC) for all dually eligible Medicaid recipients. The MLTC program rolled out in New York City beginning August 2012, and it is expected to be implemented throughout the state starting in 2013.

One of our greatest concerns is with regard to the limitations being placed on the provision of aid continuing, *i.e.*, the continuation of benefits provided during the appeals of reductions or discontinuances of Medicaid services.

The legal basis for aid continuing for traditional Medicaid is found in federal and state law. See 18 N.Y.C.R.R. § 358-3.6 (2012), 42 CFR 431.230 (2012). The explanation of the aid-continuing benefit is best illustrated by the notable case of *Mayer v. Wing*, which enjoined the City from arbitrarily reducing or discontinuing home care services:

> Every recipient of home care services must be reauthorized at least once a year. See 18 N.Y.C.R.R. 505.14(b) (5) (iii). When the recipient is due for reauthorization, the same procedures used for initial assessments are mandated, including a new physician's order, and nursing and social assessments. See 18 N.Y.C.R.R. 505.14(b)(5)(ix). Where, upon reauthorization, the City Defendant reduces a recipient's level of care, the recipient has the right to request a fair hearing within 60 days of the notice date. The

> recipient is entitled to receive "aid-continuing" pending the hearing if her request is made before the agency's mailing of the notice. See N.Y.C.R.R. Subpart 358-3.

Mayer v. Wing, 922 F.Supp. 902, 905 (S.D.N.Y.1996).

The right to receive services pending the hearing could be life saving for these clients, who are often among the frailest and most in need of the continued services. For example, when the City recently engaged in another round of reductions - eventually enjoined by the same judge who wrote the Mayer decision - the aid-continuing right protected the affected Medicaid recipients. Unfortunately, under mandatory managed care, different rules apply.

According to 42 CFR 438.420, where a Managed Care Organization (MCO) reduces or changes a care plan, the agency is required to continue benefits only through a previous "authorization" period. We contend that this section of the federal regulation is in conflict with long established state law and was not specifically intended to apply to managed long-term-care plans serving chronically ill elderly and disabled recipients. Section 365-a(8) of the New York Social Services Law provides more protection than the federal law, and we would like to ensure that it is recognized and enforced in this context. The relevant section of the New York law states:

> When a non-governmental entity is authorized by the department pursuant to contract or subcontract to make prior authorization or prior approval determinations that may be required for any item of medical assistance, a recipient may challenge any action taken or failure to act in connection with a prior authorization or prior approval determination as if such determination were made by a government entity, and shall be entitled to the same medical assistance benefits and standards and to the same notice and procedural due process rights, including a right to a fair hearing and aid continuing pursuant to section twenty-two of this chapter, as if the prior authorization or prior approval determination were made by a government entity.

This law was intended to protect recipients of Medicaid services provided by private subcontractors so that they would receive the same rights and benefits afforded all New York Medicaid recipients. This law is directly applicable to the current implementation of the MLTC system.

Under traditional Medicaid, the fair hearing process can take weeks or months, first to file for a hearing, receive a hearing date, prepare witnesses and other documentation for the hearing, and then to wait for the decision. Further, the recipient is at the mercy of the agency throughout this process, which is precisely why aid continuing is so important. The process for an appeal of a MLTC decision has an additional step of an internal review, which is required prior to a fair hearing, creating the possibility of an even longer time frame for the appeals process.

Consider the following scenario: an authorization period runs for a six-month period. One week prior to the expiration of the authorization period, the recipient receives a notice stating that the care plan has been changed and there will be a reduction or discontinuation of services. The recipient is required to participate in an internal review with the MLTC before she can file for a fair hearing. In the meantime, the prior authorization period expires, and the MLTC is not required to continue paying for the prior services. The individual is possibly a wheelchair-dependent twenty-four-hour home-care recipient who is now without services while the appeal is in process. She is stuck in her wheelchair with no help.

On whom does the burden fall in this scenario? We have been told by the Department of Health that the licensed home care agencies (vendors) who subcontract with MLTC plans are legally prohibited from leaving the recipients with unsafe care plans. They may find themselves required to continue services without full reimbursement. Or will the recipients themselves, or their families, have to pay for care during this interim or - more likely - will they suffer without care?

It is our position that the agencies providing the care will not be able to survive financially if they are forced to take on the risk of providing care to these recipients, who have limited resources and income, without the promise of reimbursement from the MLTC. The only other option is for the vendors to cease to provide the care after the authorization period. The potential for harm to these frail and vulnerable individuals is extremely high.

For all of these reasons, our Committee is calling attention to this gap in the implementation of the MLTC program. We urge the legislature to be proactive in this matter and to work with the Department of Health to close this gap so as to avoid unintended and possibly dangerous consequences.