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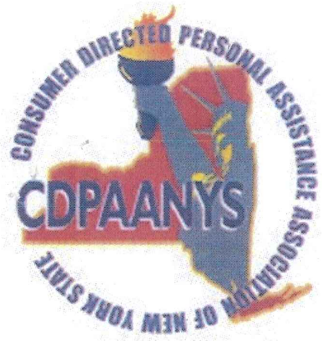

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TESTIMONY OF

Consumer Directed Personal Assistance Association of New York State

to:

Senate and Assembly Joint Hearing on Health

Delivered by:

Bryan O'Malley

February 12, 2018

Good evening Chairwoman Young, Chairwoman Weinstein, Senator Hannon, Assembly Member Gottfried, and all of the Legislators here this evening. As the only organization in the state dedicated solely to the Medicaid program's Consumer Directed Personal Assistance Program (CDPA), the Consumer Directed Personal Association of New York State (CDPAANYS) appreciates the opportunity to inform you of the impact of this year's proposed budget on the program.

CDPAANYS represents the agencies that administer the CDPA on behalf of Medicaid recipients, called fiscal intermediaries, as well as the Medicaid recipients who utilize it, called consumers. The program is an alternative to home care that allows seniors and people with disabilities in need of long-term supports and services to take control of critical aspects of their care. who use it, and the personal assistants who provide these critical services. On behalf of the over 55,000 New Yorkers who either use or are employed through CDPA, we appreciate the opportunity to inform you of the impact of this budget proposal on CDPA and those who rely on it.

CDPA is a Medicaid home care program that allows individuals to recruit, hire, train, supervise and terminate their own workers, called personal assistants, instead of having an agency provide workers for them. The consumers work with organizations called fiscal intermediaries to contract with Medicaid; provide payroll services; and more.

According to the Bureau of Labor Statistics, personal care is the fastest growing industry in the State. Within personal care, CDPA is the fastest growing sector of the industry. We have experienced 20% program growth each of the last five years, and there is no expectation that this will slow. Consumers who utilize the program currently employ approximately 35,000 individuals. Unfortunately, even with this dramatic increase does not reflect the actual need. Based upon industry averages, with 25,000 to 30,000 consumers using the program, actual workforce need is approximately 40-45,000, a dramatic shortage in an industry where the lack of a worker means the inability to go to the bathroom or get out of bed.

This is why CDPAANYS has prioritized increases in wages for the past five years, and it is why we are again focusing on this issue. While FIs are some of the most effective stewards of taxpayer dollars, using on average $0.90 of every Medicaid dollar to pay for wages, benefits and fringe costs, appallingly low reimbursements based on a lack of regulation and a decade of frozen ceilings has created a situation where PAs are the lowest paid workers in our economy. In many cases, they are paid $1.10-$1.50 per hour less than their counterparts in the fast food industry.

Last year, the Legislature partially remedied this situation. By adding CDPA to wage parity within New York City, Long Island, and Westchester, the Legislature successfully raised wages. However, this action drew further attention to the problems stemming from a lack of regulation of the managed care industry. In privatizing Medicaid, the state refused to involve itself in contracts. This means that Fidelis pays most FIs $17.70 per hour in New York City when the FI is required by law to pay workers $17.09 in wages and benefits. This leaves $0.61 for worker's compensation, unemployment, payroll taxes, administrative services such as billing, and more. These services typically cost $5-6 per hour.

This is unsustainable. FIs throughout the downstate area are trying to deal with margins that place them in financial peril. To their credit, DOH has attempted to resolve these issues. The failure to resolve them despite this intervention indicates that the law does not contain sufficient provisions to make managed care plans reimburse at a rate that is sufficient to cover costs.

The situation does not improve much when we look at fee-for-service, which still accounts for approximately 40% of CDPA consumers.

Fee-for-Service (FFS) Medicaid rates are arrived at through a combination of two different funding components: direct care and administrative and general costs. Direct care costs are capped based upon the region of the state a provider is located. Administrative and general costs are capped at a percentage of your total rate.

When the State eliminated the trend factor adjustment a decade ago, it also, indirectly, eliminated the ability to adjust the direct care ceiling upwards. This means that home care agencies and FIs have not seen an adjustment to their direct care ceiling for a decade, meaning every provider is at or above their ceiling.

Ironically, those providers who run administratively efficient could, in theory, increase their rates by giving management raises; however, even the smallest raise for direct care staff would result in further organizational losses. This is not reflective of New York values, and it is singularly responsible for creating the workforce crisis in which we find ourselves.

Further complicating matters is the disparate reimbursements for different services, which according to the Centers for Medicare and Medicaid Services (CMS), discriminate against New Yorkers based upon disability type. Community habilitation, a service in the developmental disability spectrum of services substantially similar to CDPA, has reimbursement over 200% greater than CDPA. While this has always been the case, a provision of the Affordable Care Act (ACA) gives it new urgency.

The ACA contained a new policy, Community First Choice (CFC), which provides states with additional federal matching funds of 6% to provide community-based services to nursing home eligible individuals. In 2014, the Centers for Medicare and Medicaid Services (CMS) approved New York's State Plan Amendment (SPA) to include CFC, on the condition that the state fix the aforementioned discriminatory reimbursement system. They gave New York State an October 2016 deadline to fix this injustice.

It has been more than a year since the deadline passed. New York has collected over a half a billion dollars in additional FMAP. Yet, we remain noncompliant in regards to reimbursement, with no plan on how to address this. Not only are we jeopardizing future federal dollars, but CMS may demand we return the money already received.

Furthermore, two years ago, the Legislature designated this extra CFC funding to be additional funding for services related to funding community-based services and supports. The intent of this language was that the money be "additional" and, since it is Federal money, that it exist outside of the global cap, which applies to state funds only.

When DOH implemented this language, they subjected this Federal funding to the global cap and therefore, using the argument that money is fungible, merely pulled an equal amount of funding out of Medicaid and used it for a different purpose, clearly violating the intent of the Legislature in earmarking this funding stream.

By clarifying the language to clarify that the funds are Federal and eliminate loopholes to its intended funding, the State could go a long way towards financing increased reimbursement and wages in CDPA and home care.

The Executive Budget does provide $3 million dollars to bolster the wages of home care workers and PAs, in rural areas, in fee-for-service. Apart from the extremely narrow focus of the study, this money comes with a catch: it must first go to funding a wage study of rural, fee-for-service (FFS) providers.

We welcome a study of wage inadequacies, as we had requested in previous Workforce committee hearings. However, the study contained in this budget is arbitrarily confined to FFS providers, despite inadequate wages being a pervasive problem within all types of Medicaid care plans. It is also limited to rural areas of the state. The Consumer Directed Personal Assistance Association of New York State's 2017 report, *The High Cost of Low Wages*, verified that the workforce crisis touches every corner of the state, with some of the most extreme examples of worker shortages occurring in Westchester and Long Island.

Forcing employees to pay for a study to identify the inadequacy of their wages is simply mean-spirited. These employees know how little they're paid as they struggle to pay their bills. After whatever auditing firm the State contracts with takes their fee, the money actually making it to the PAs will be scant.

New York has decided that while it doesn't want to involve itself with actually helping struggling workers in a vitally important and increasingly growing field, it should dictate how FIs spend their money through the creation of a marketing ban. One need not scratch very far beneath the surface to realize that this policy is designed to keep consumers in the dark about a program for which they are eligible and can allow them to remain in their home while receiving essential services.

In fact, the Department of Health confirmed to CDPAANYS in a public meeting that the change was being proposed because seniors and people with disabilities were seeing advertisements for services, signing up for MLTC benefits, and utilizing CDPA. The Department did not contend that services were not needed, or that somehow people who did not qualify were utilizing them, it is merely the fact that the program is leading to higher than anticipated growth in Medicaid.

This is unacceptable. If the Department wants to eliminate CDPA as a benefit, they should propose that and we could all debate the merits of such a proposal. However, they know this would be an unpopular proposal with high political consequences, therefore, they propose to prevent people who need it from hearing about it.

This is nothing more than a backdoor benefit cut and it needs to be rejected.

The budget contains two provisions that undermine the philosophy of CDPA, as well as the notion that competent adults should be allowed to make decisions for themselves.. The first requires criminal background checks on all staff members of health homes that offers services to people with developmental disabilities, as well as any home and community based services provider serving individuals under the age of 21 who are enrolled in a managed care plan. This would apply criminal background checks to CDPA for the first time, despite the fact that the program was specifically exempted by the Legislature several years ago when these provisions were added to personal care and home care. The nature of consumer direction, where we provide consumers with full control over their services, makes this provision untenable.

The clearest indication that the background check language was not properly vetted is that it contains a stipulation that PAs can work while a background check is pending, as long as they

are supervised by another PA with at least one year of experience. Though this may appear to be positive compromise, it amounts to Medicaid fraud by violating the rule against duplication of services. Ironically, a rule designed to identify a potential employee's criminal history would lead the Medicaid recipient into engaging in criminal conduct themselves.

Central to CDPA is the philosophy of "dignity of risk". The adults who utilize the program have been deemed mentally competent; if they were not, they would not qualify for CDPA. Though our consumers may have physical disabilities, they are as capable of making sound decisions as mainstream society. To insist that the employees they hire must first be subjected to a criminal background check, no matter how well meaning, infantilizes these adults. Consumers already have the right to submit potential workers to these tests if they so choose.

This budget also adds PAs to the list of mandatory reporters for child abuse or maltreatment. Mandatory reporting laws are designed to protect children and individuals who are unable to self advocate. However, an individual between the ages of 18 and 21 is considered an adult, and ignoring that is, at best, patronizing.

Another fundamental problem in holding PAs responsible to act as mandatory reporters, similar to the criminal background check requirement is that in CDPA, consumers determine who they employ. If PAs are established mandatory reporters, they would be forced to report perceived abuse or neglect their employers are subjected to. This not only violates the employer's dignity, it is also illogical; the basis for mandatory reporting laws is to root out abuse employees witness taking place in their workplace, not against their employers themselves. If we determine that consumers are no longer qualified to determine who they want to employ, then CDPA ceases to exist.

While clearly well-intentioned, we encourage you to protect CDPA and an individual's right to assume risk, rejecting the proposals to force PAs to undergo a criminal background check and act as mandatory reporters.

Several years ago, Governor Cuomo laid out a landmark *Olmstead Plan*, where he outlined in detail extensive plans to remove people from nursing homes and other institutions, instead bringing them into the community. In this budget, several provisions will strengthen, rather than reduce, the institutional bias.

Managed Long Term Care (MLTC) plans control the price of health coverage by receiving one rate paid by the state for each person enrolled, no matter their particular care requirements. Because of this, MLTCs have a financial incentive to serve their members in the community, which is generally less expensive than a nursing home. However, a proposal that would remove nursing homes from the MLTC benefit package if an individual is there for over 6 months would remove this disincentive. In fact, it would ensure that high needs individuals in the community would be the most expensive. Knowing that they could eliminate this cost by placing these individuals in nursing homes, plans will have an extreme financial incentive to do so.

Further, the proposal makes no financial sense. The Governor purports to save $170 million by instituting this proposal. However, a nursing home costs the state $8,000 per month, while a MLTC capitated benefit is just over $4,000. How the Governor proposes to save $170 million by paying twice as much for services is a financial trick that belies explanation. **It is incumbent on the Legislature to uphold *Olmstead* and ensure that Nursing homes must remain a part of the MLTC benefit package.**

Another fundamental change to MLTC would close this type of plan to any individual scoring less than a nine on their Uniform Assessment System. Last year, the legislature rejected a proposal requiring individuals scoring a five (the baseline score for an institutionalized level of care) or above to be cared for in nursing homes. This year, it appears the administration is taking a different tack by tying an arbitrary and capricious number to the ability to access this care plan. There is no clarification about whether individuals scoring below nine will be moved to FFS or mainstream, but will further destabilize the MLTC industry and push that population back to the counties, who dismantled their long term care infrastructure years ago. It will also disrupt their continuity of care, forcing them to either delay needed services or enter the nursing home system. **The proposal to change the point at which an individual is eligible for MLTC must be rejected.**

Consumer choice within MLTC is also under attack this year. Mainstream Medicaid recipients are locked into their provider plans for 12 months at a time. The state, recognizing that MLTC enrollees have a higher rate of interaction with the healthcare system, has allowed them to switch MLTC plans monthly, if needed. This budget would apply a 12 month lock in across the board, removing an individual's right to choose when it comes to services that are critical to their dignity and independence.

MLTC plans can choose to stop contracting with FIs with little advance notice to consumers. If your FI is no longer in your plan's network, you and your PA must now find a new FI that is. In the course, the PA may lose accrued sick or vacation time. **The Legislature should ensure that those in need of long term care continue to have the right to choose what plan works best for them and not lock them into a plan needlessly.**

CDPAANYS supports many provisions expressed by others testifying before this committee. In particular, we urge the following action on these proposals in the Governor's budget:

- Refuse provisions to end spousal protection,
- Refuse the addition of 1,000 new ALP slots
- Reject provisions that allows the Commissioner to make Medicaid rate adjustments in the case of Medicaid MCOs with reserves in excess of the minimum contingent reserve requirement;
- Reject provisions that allow MCOs must collect a fee from providers for recovering overpayments, a task that they are currently required to undertake without added fees;
- Reject new onerous fines from the OMIG;
- Modify a requirement that DOH may require any Medicaid provider within FFS or MC to submit cost reporting to prevent providers from having to submit their cost report to each plan they contract with;
- Include Fiscal Intermediaries in the Statewide Health Care Facility Transformation Program that provides funding to community based health care organizations (including MCO contractors) to modernize and expand services.
- Accept provisions to expand the definition of "Remote Patient Monitoring" to include transmissions, including phone calls, made after and/or in response to an initial transmission.

I appreciate the ability to offer testimony today and welcome any questions.